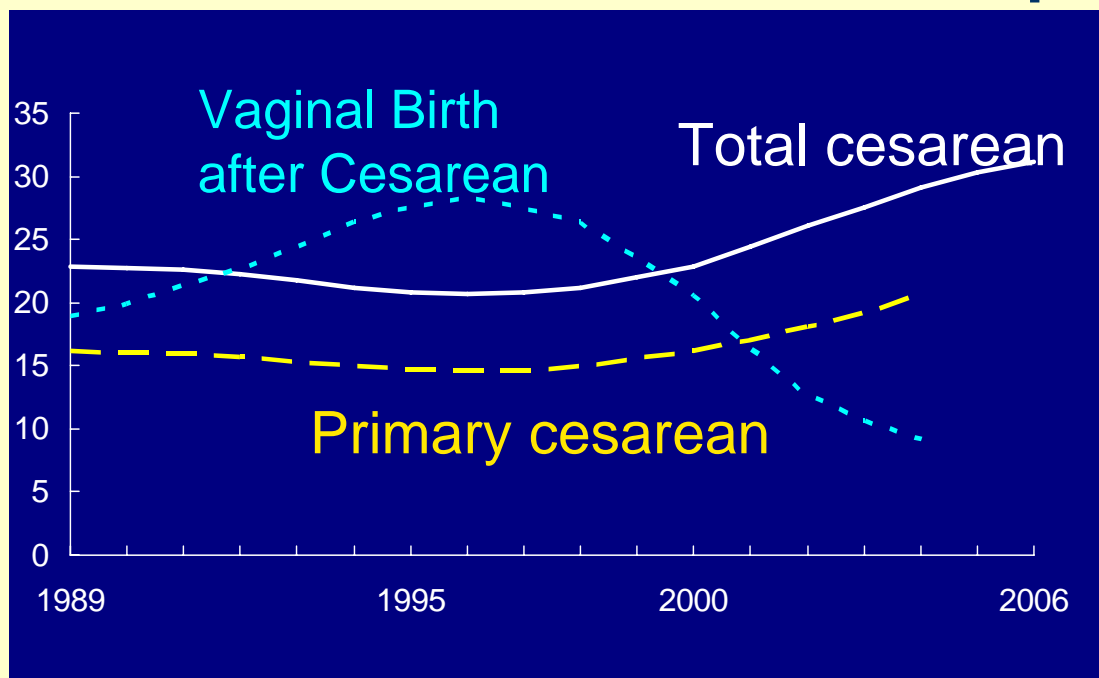


Understanding the Debate over Cesarean Section: From Data, to Practice, to Mothers' Perspectives



**Listening to Mothers:
The Aftermath of Cesareans
September 25, 2008
Wolfert's Roost , Albany, NY**

Key Questions

- Is the U.S. really doing that badly?
- What are we doing about it?
- Are women the cause of the problem?
- Is there a new childbirth movement?

Is the U.S. really doing that badly?

How Do we Compare Outcomes?

Neonatal Mortality Rate

***Infant Deaths in
First 28 days
X 1,000***

***Live
Births***

Outcomes: Neonatal Mortality Rates (2000)

Rank	Country	Rank	Country	Rank	Country
1	Singapore	15	Monaco	29	Luxembourg
2	Czech Republic	16	Norway	30	Netherlands
3	Finland	17	Portugal	31	New Zealand
4	Iceland	18	Spain	32	Slovenia
5	Japan	19	Switzerland	33	United Kingdom
6	San Marino	20	Andorra	34	Belarus Estonia
7	Sweden	21	Brunei	35	Croatia
8	Australia	22	Canada	36	Lithuania
9	Austria	23	Cuba	37	Malaysia
10	Belgium	24	Cyprus	38	Malta
11	France	25	Denmark	39	Qatar
12	Germany	26	Greece	40	Slovakia
13	Italy	27	Ireland	41	United Arab Emirates
14	Korea	28	Israel	42	United States

Source: UNICEF. 2008 *The State of the World's Children*. Table 1

Outcomes: Neonatal Mortality Rates (2000)

Rank	Country	Rank	Country	Rank	Country
1	Singapore	15	Monaco	29	Luxembourg
2	Czech Republic	16	Norway	30	Netherlands
3	Finland	17	Portugal	31	New Zealand
4	Iceland	18	Spain	32	Slovenia
5	Japan	19	Switzerland	33	United Kingdom
6	San Marino	20	Andorra	34	Belarus Estonia
7	Sweden	21	Brunei	35	Croatia
8	Australia	22	Canada	36	Lithuania
9	Austria	23	Cuba	37	Malaysia
				38	Malta
				39	Qatar
				40	Slovakia
				41	United Arab Emirates
				42	United States

TWO PROBLEMS

- (1) *Comparisons* – Seven countries highlighted had fewer combined births than the state of New Mexico
- (2) *Measurement* – Is neonatal mortality the best measure to use?

Comparisons to the U.S.

Perinatal Mortality Rate

(Helps account for measurement differences)

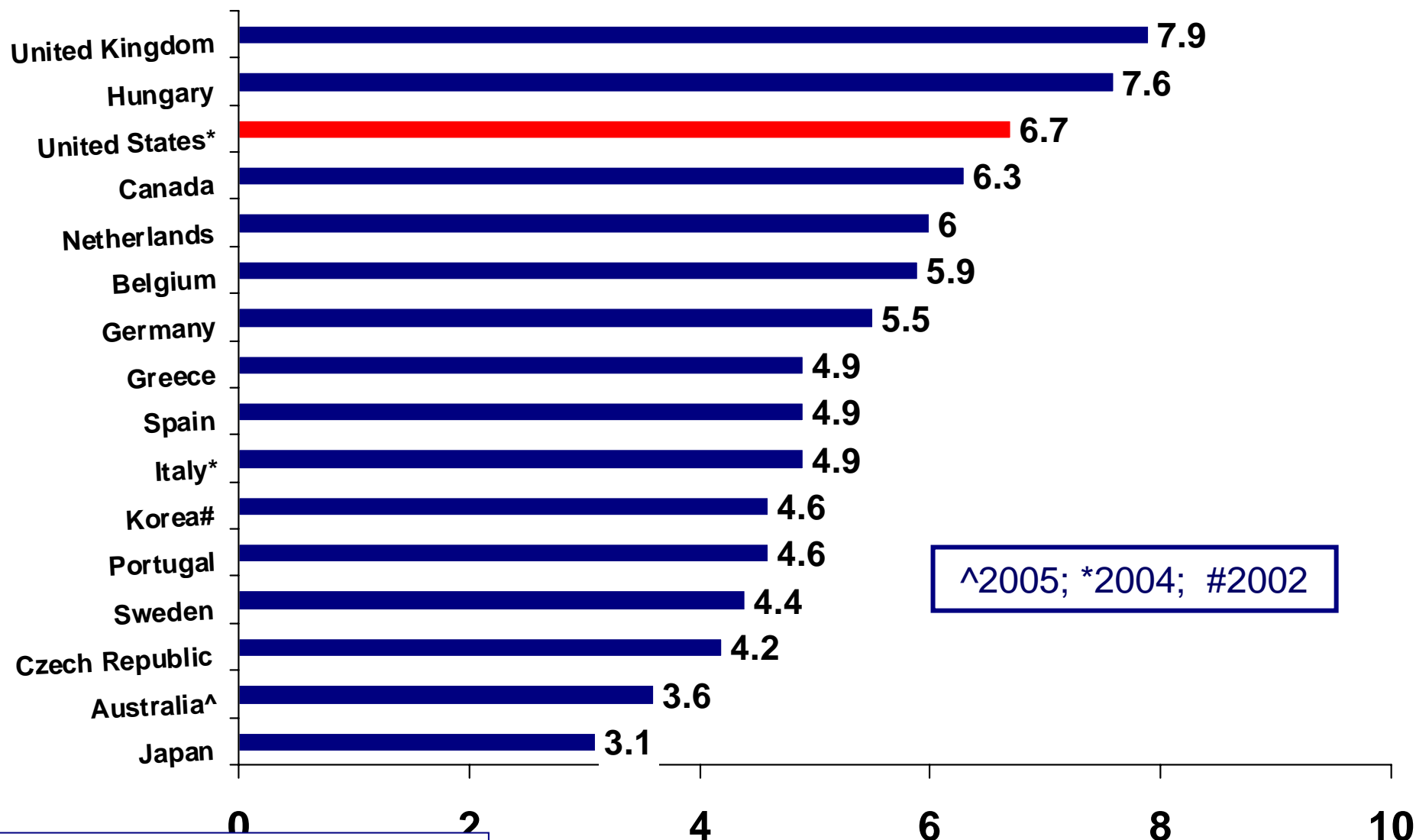
Fetal deaths + deaths in the first week

X 1,000

Live births + fetal deaths

Compare to industrialized countries with at least 100,000 births in 2005: Australia, Belgium, **Canada**, Czech Republic, **France**, **Germany**, Greece, **Italy**, **Japan**, Netherlands, Portugal, **S. Korea**, **Spain**, Sweden, **U.K.**

National Perinatal Mortality Rates, 2006, Industrialized Countries with 100,000+ Births



Maternal Mortality Rates

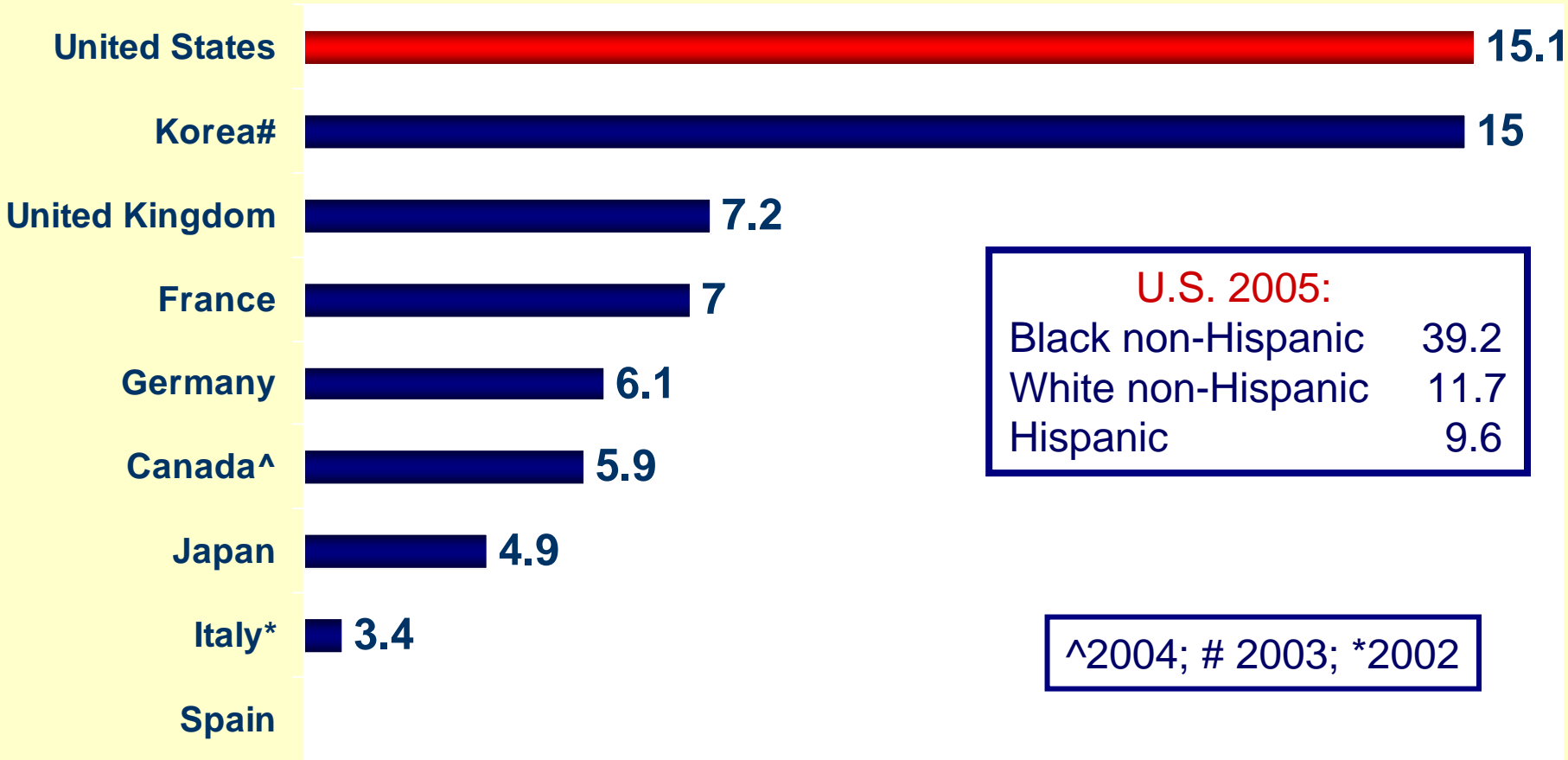
Maternal Mortality Rate

Maternal Deaths all causes

X 100,000

Live births

Maternal Mortality Rates, (per 100,000 *births*), 2006, Industrialized Countries with 300,000 + births



U.S. 2005:	
Black non-Hispanic	39.2
White non-Hispanic	11.7
Hispanic	9.6

^2004; # 2003; *2002

Maternal Mortality Rate

3 16

Sources: OECD Health Data 2008; NCHS. 2008. Deaths, Final Data, 2005.

Other countries do better because the U.S. is different:

- more diversity,
- weaker social support system,
- inequality in our health care system.

What if we compared subgroups in the U.S. to other countries?

US Subgroups in Comparative Context with other Industrialized Countries

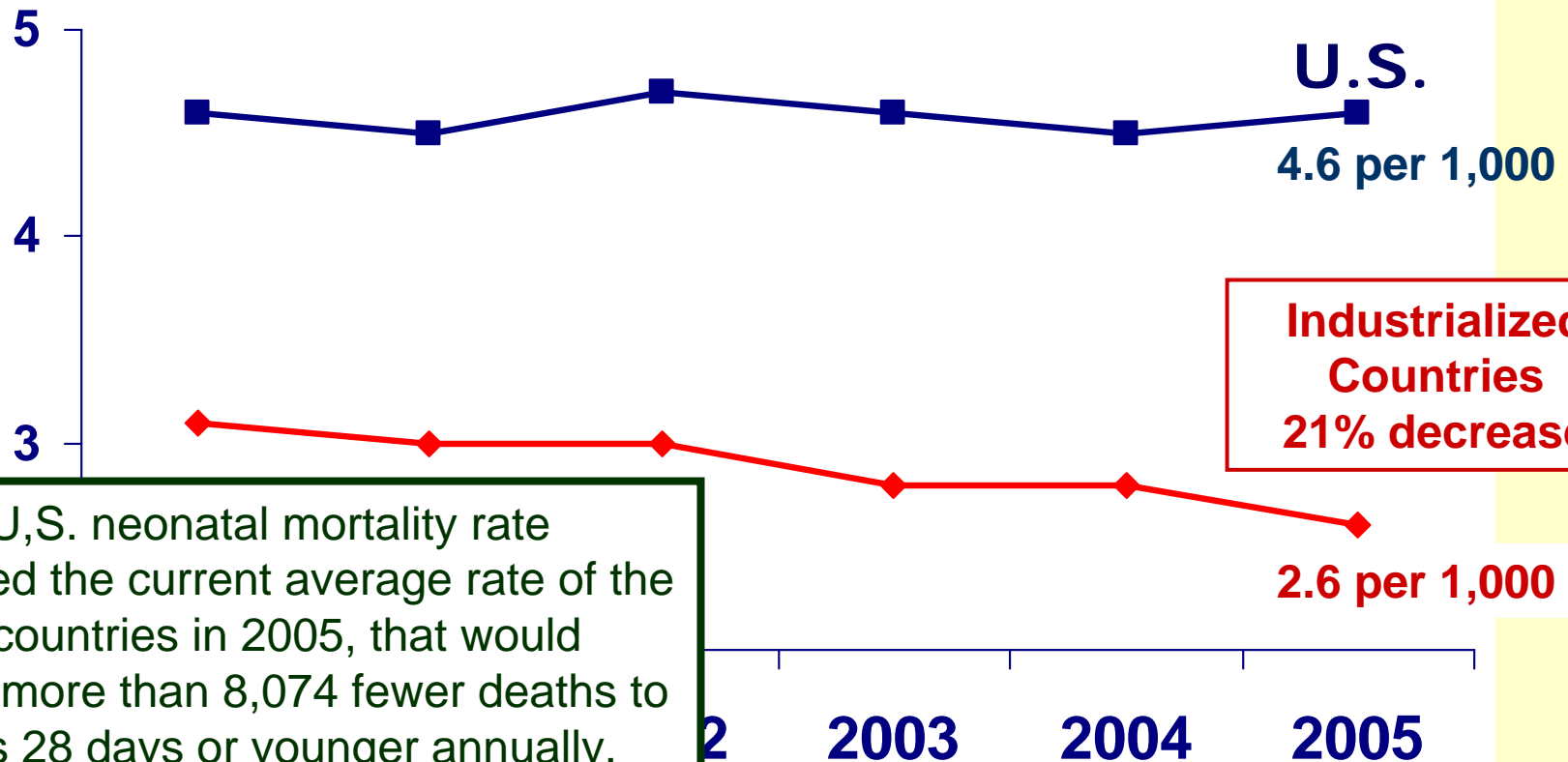
US Subgroup	U.S. IMR 2003	Rank (16 - 100K)	Rank (9 - 300K)
<i>All</i>	6.9	16	9
<i>Prenatal Care in 1st Trimester</i>	6.2	16	9
<i>White Non-Hispanic</i>	5.7	16	9
<i>White NH, Native Born</i>	5.7	16	9
<i>White NH, Prenatal Care in 1st Trimester</i>	5.2	13	6
<i>White NH, 16+yrs Education</i>	3.7	3	2

Source: U.S. subgroups: Mathews et al. 2006. Infant mortality statistics from the 2003 period linked birth/infant death data set. NVSR v. 54 (16).Hyattsville, MD: NCHS, Table 2. *Other IMRs from *OECD Health Data 2007*.

Table 4. Infant deaths and infant mortality rates by age, race, and Hispanic origin: United States, final 2004 and preliminary 2005 **Source: NCHS. (2007) Preliminary Deaths, 2005.**

Age, race, and Hispanic origin	2005		2004	
	Number	Rate	Number	Rate
All races ¹				
Under 1 year	28,534	6.89	27,936	6.79
Under 28 days	18,834	4.55	18,593	4.52
28 days–11 months	9,699	2.34	9,343	2.27
Non-Hispanic white				
Under 1 year	13,092	5.73	13,046	5.68
Under 28 days	8,563	3.75	8,638	3.76
28 days – 11 months	4,529	1.98	4,408	1.92
Total black				
Under 1 year	8,663	13.69	8,494	13.79
Under 28 days	5,717	9.04	5,622	9.13
28 days–11 months	2,946	4.66	2,872	4.66
Hispanic ²				
Under 1 year	5,782	5.88	5,321	5.62
Under 28 days	3,897	3.96	3,633	3.84
28 days–11 months	1,885	1.92	1,688	1.78

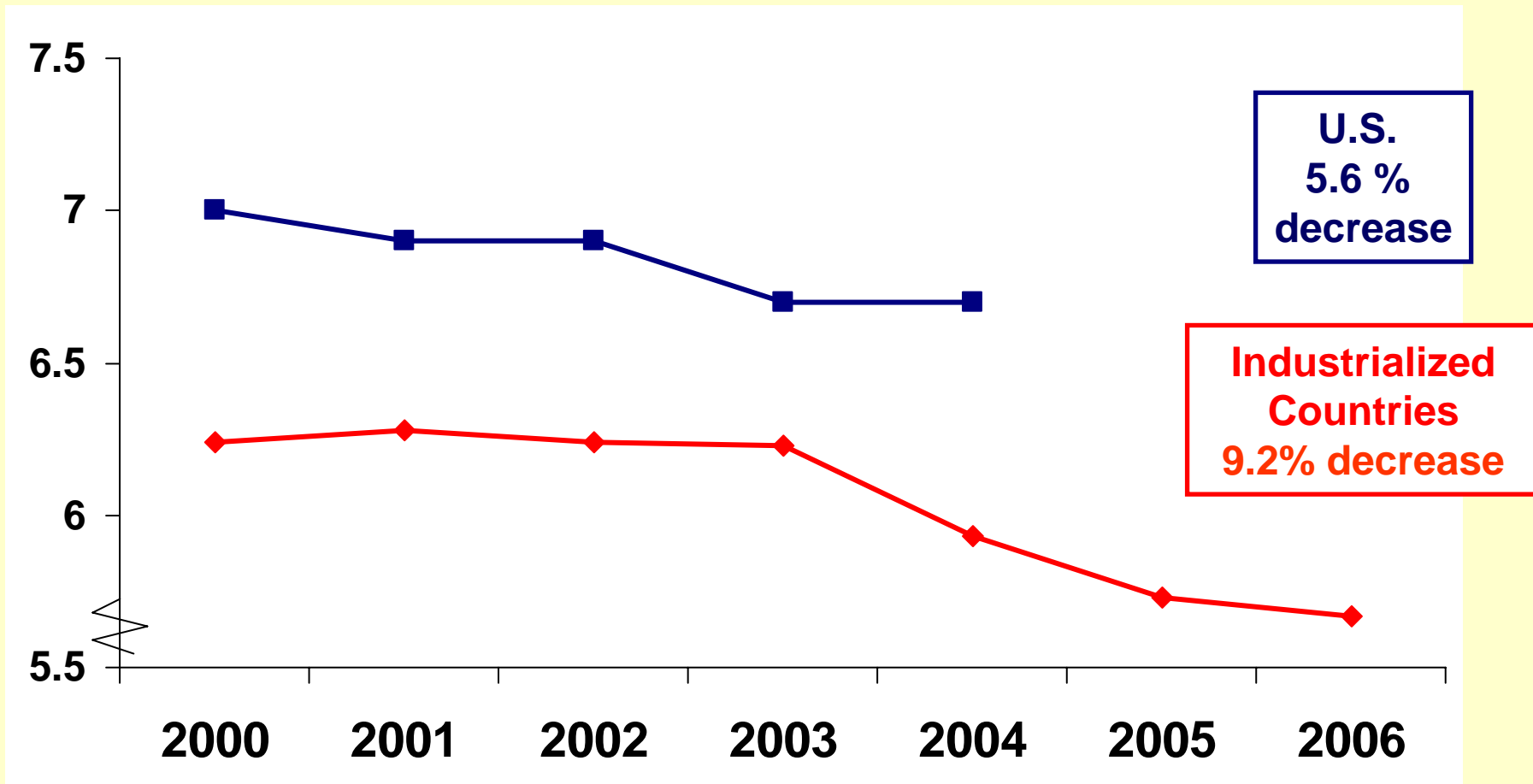
Neonatal Mortality Rate, 2000-2006, U.S., & Ave. for Industrialized Countries*



* Countries with 100,000+ births (2006): Australia, Belgium, Canada, Czech Republic, France, Germany, Greece, Italy, Japan, Netherlands, Portugal, Spain, Sweden, U.K.

Source: OECD Health Data, 2008

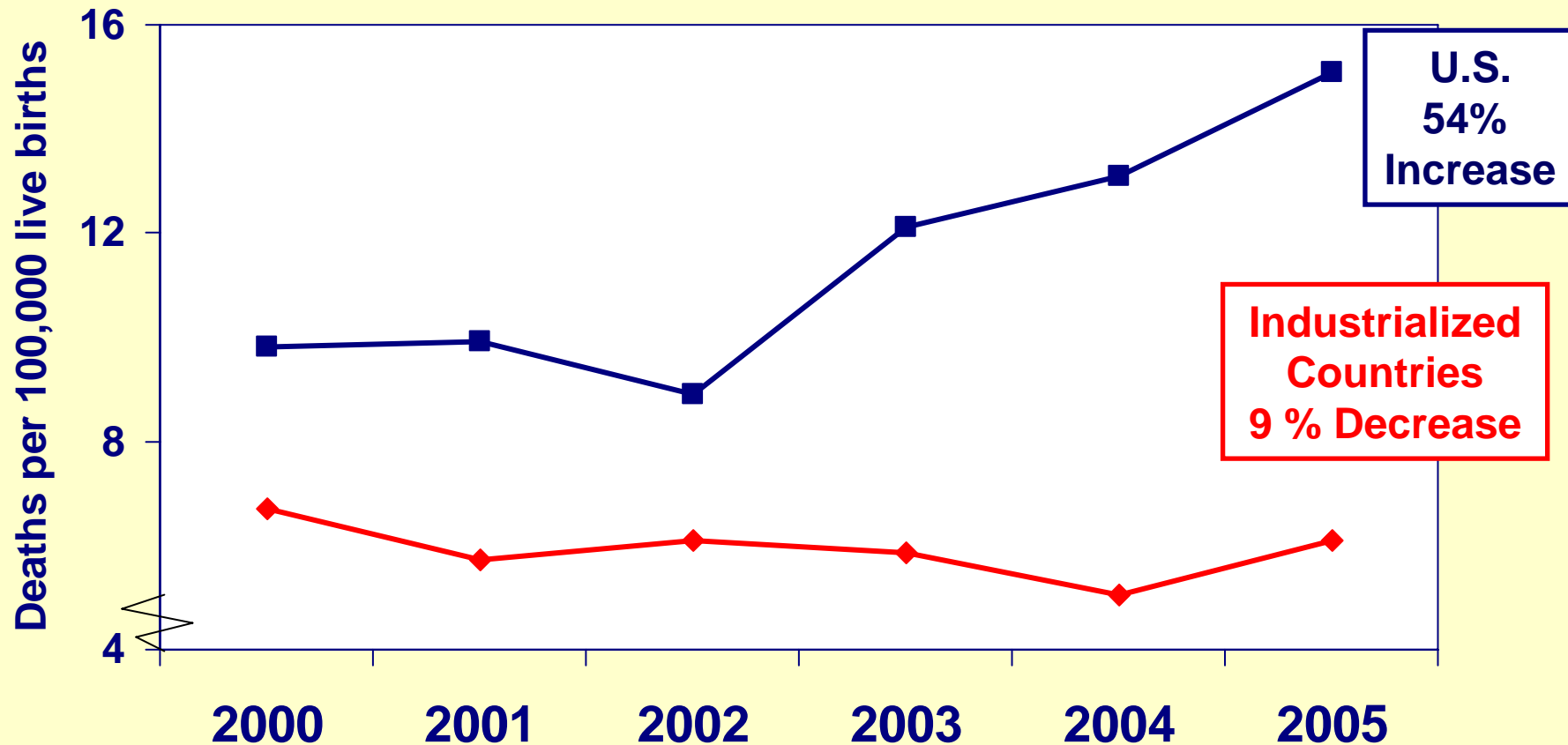
Perinatal Mortality Rates, 2000-2006 , U.S., & Ave. for Industrialized Countries*



* Countries with 100,000+ births (2006): Australia, Belgium, Canada, Czech Republic, France, Germany, Greece, Hungary, Italy, Japan, Netherlands, Portugal, S. Korea, Spain, Sweden, United Kingdom

Source: MacDorman M. *Fetal and Perinatal Mortality, U.S., 2004*. 2007.NCHS V. 56#3 and OECD Health Data 2008

Maternal Mortality Rates, 2000-2005, U.S. & Ave. Industrialized Countries*



* Countries with 100,000+ births (2006): Australia, Belgium, Canada, Czech Republic, France, Germany, Greece, Hungary, Italy, Japan, S. Korea, Netherlands, Portugal, Spain, Sweden, United Kingdom

What's the Response to these Outcomes?

The biggest change in U.S. maternity care in the last 10 years

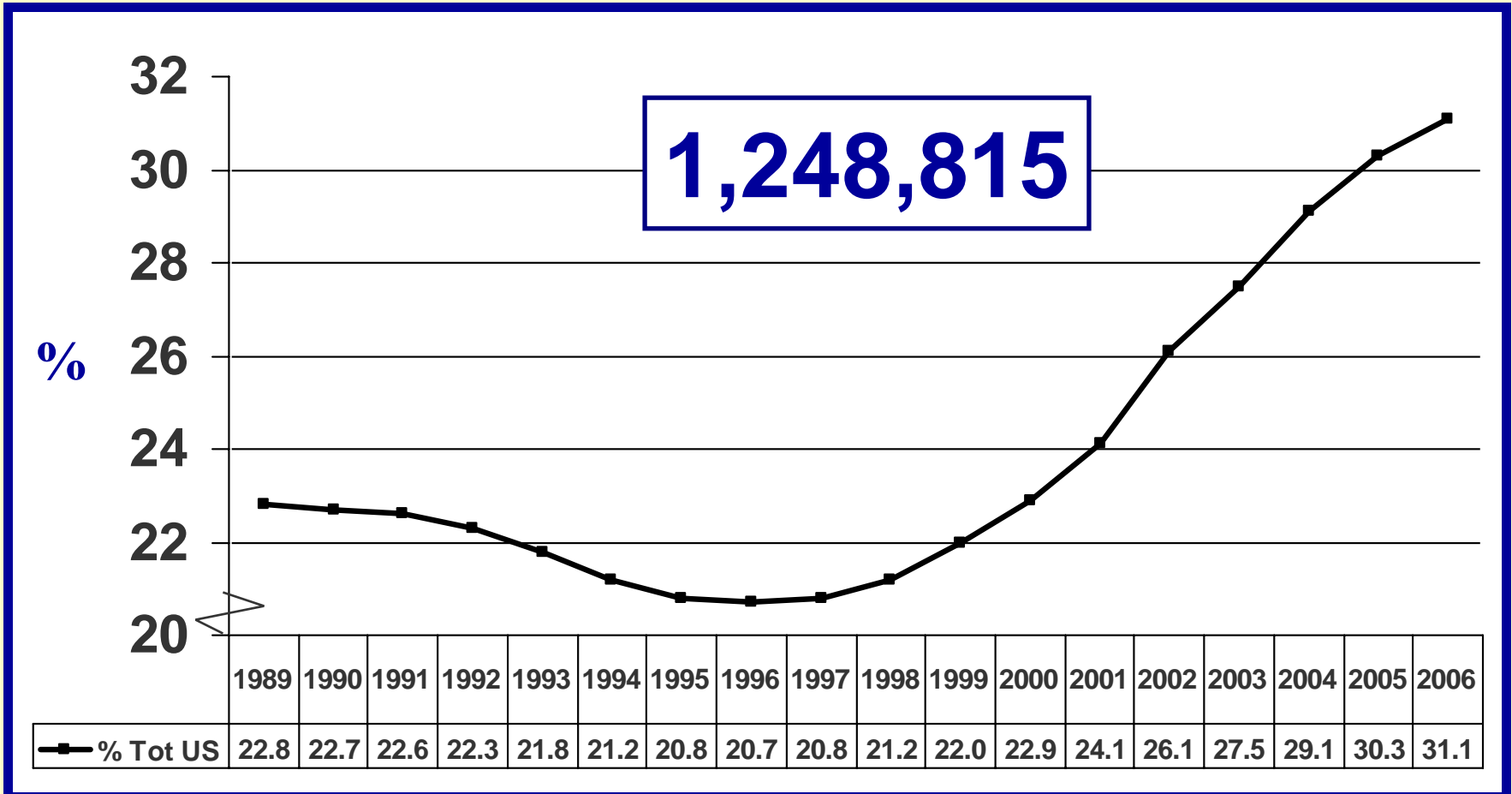
Cesarean Rates in Low Income Countries

Low Income	% Cesarean	Year
Chad	0.4	1996-1997
Ethiopia	0.6	2000
Niger	0.6	1998
Burkina Faso	0.7	2000
Cambodia	1.0	2001
Nepal	1.0	2000
Mali	1.2	2001
Tajikistan	1.3	2001
Yemen	1.5	1997
Eritrea	1.6	1995
Haiti	1.7	2000
C.A.R.	1.9	1995
Togo	2.0	1998
Zambia	2.2	2001-2002
Rwanda	2.3	2000
Cameroon	2.5	1998-1999
Uganda	2.6	2000-2001
Bangladesh	2.8	1999-2000
Pakistan	2.9	1991

Low Income	% Cesarean	Year
Tanzania	3.0	1999
Mauritania	3.3	2001
Uzbekistan	3.3	2000-2001
Viet Nam	3.4	1997
Benin	3.5	2001
Turkmenistan	3.6	2000
Nigeria	3.7	1999
Ghana	4.0	2001
Kenya	4.0	1998
Kyrgystan	4.1	2001
Indonesia	4.2	1997
Senegal	5.0	1995
Comoros	5.3	1996
Gabon	6.0	1997
Madagascar	6.0	2000
Rep. of Moldova	6.7	2001
Morocco	7.0	1996
India	7.1	1998-1999

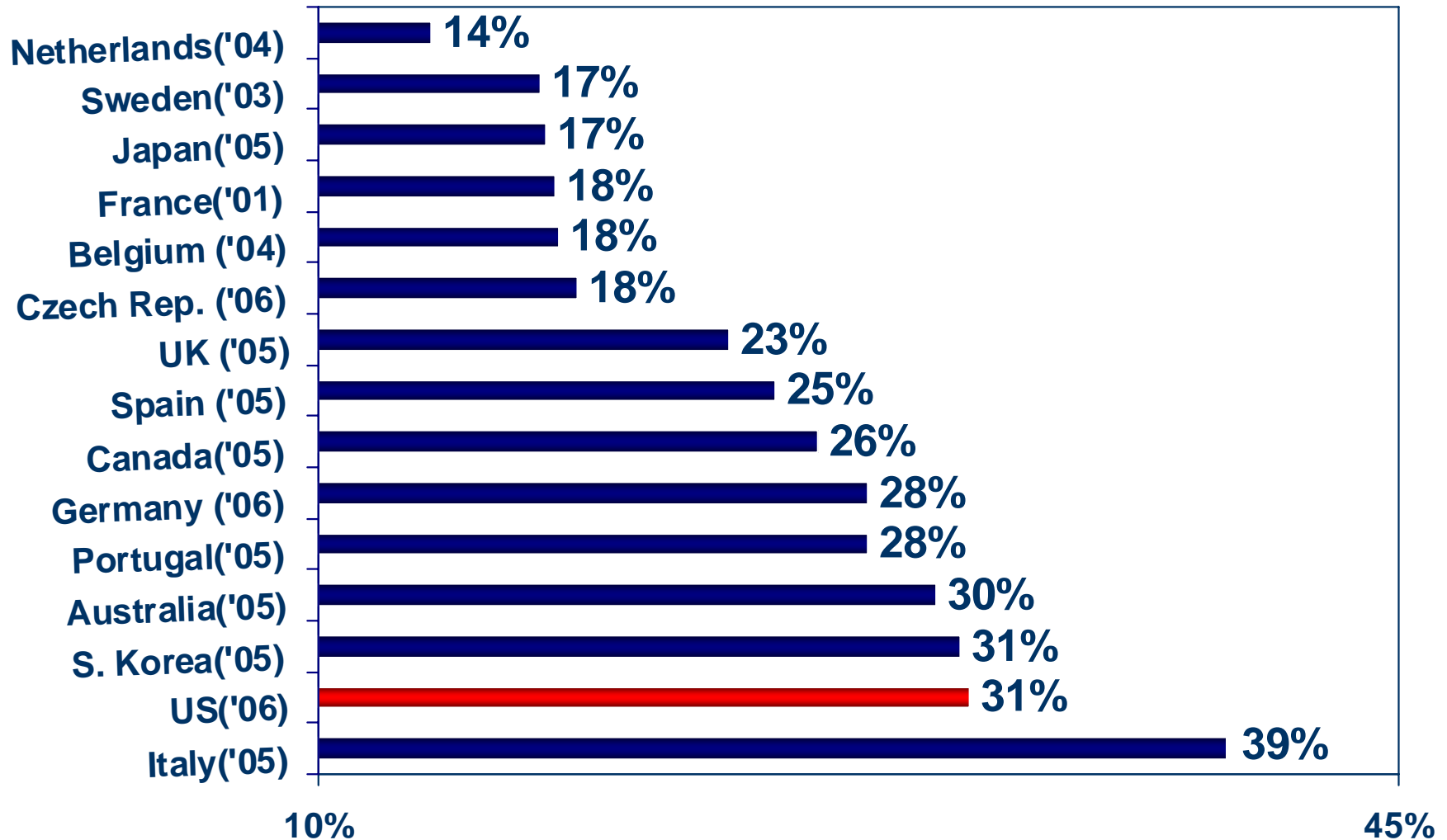
The U.S. Context

US Cesarean Rates, 1989-2006



If the 2006 cesarean rate was the same as in 1996, there would have been 443,664 fewer cesareans in the U.S. in '06.

Cesarean Rates in Industrialized Countries with 100,000+ Births



Why would a 30%+ cesarean rate be an example of overuse?

Are 30% of U.S. births high enough risk to require a cesarean?

What's the Problem with Cesareans to Low Risk Mothers?

A cesarean to address a true medical risk is not the problem since it involves a balancing of the risks associated with major surgery against the dangers associated with the medical risk.

The difficulty arises when cesareans are performed on mothers with no medical problem – you take on all the risks associated with major surgery for no medical justification.

What's the Problem with Cesareans to Low Risk Mothers?

- Infant Health Outcomes
- Maternal Health Outcomes

What's the Problem with Primary Cesareans to Low Risk Mothers?

Basic Comparison

Medically Elective Primary Cesareans

Primary Cesareans for no identified medical reason

compared to

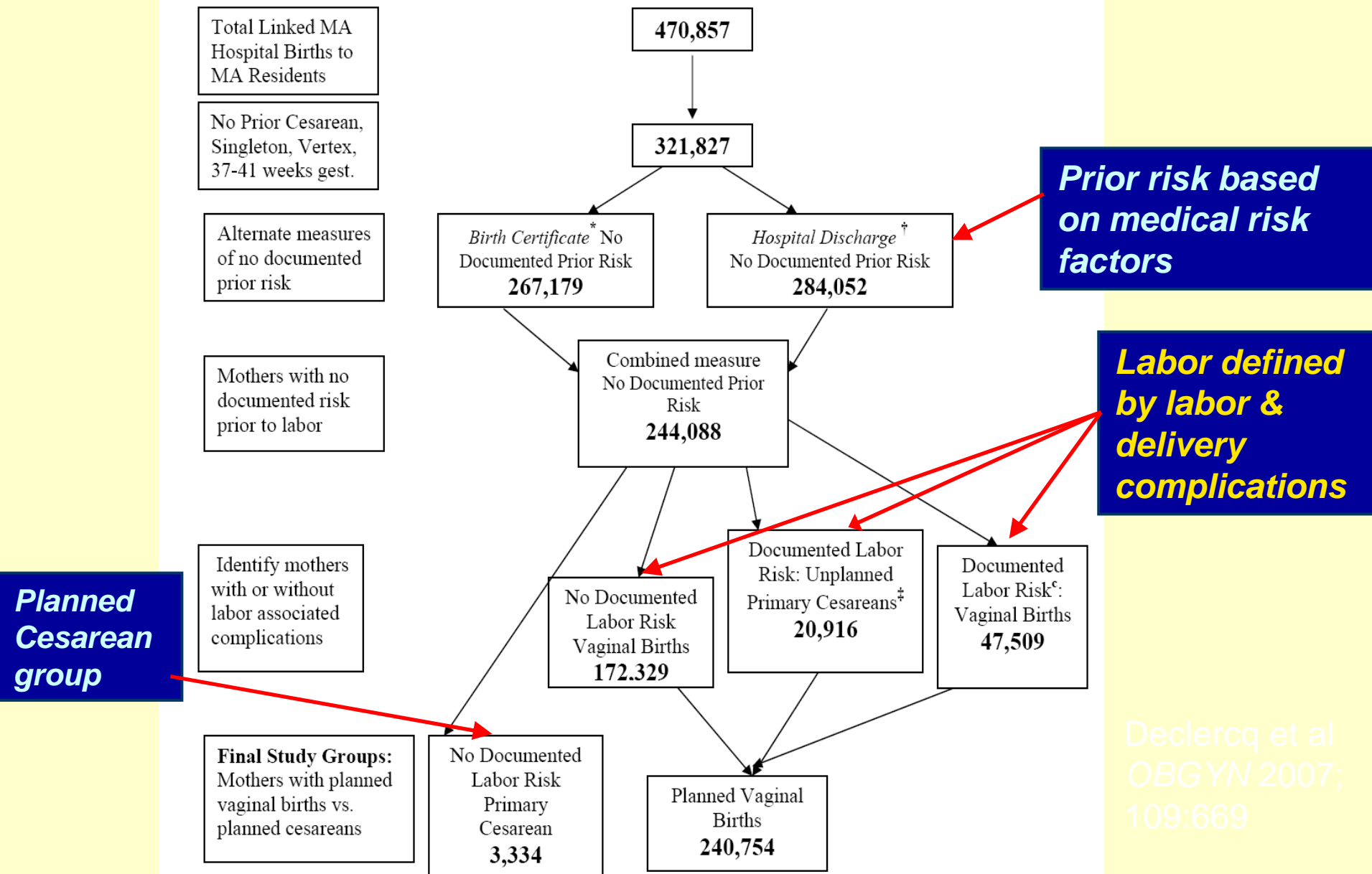
Planned Vaginal Births

Vaginal births

Unplanned cesareans for a medical reason

Figure 1 Identifying Planned and Unplanned Cesarean and Vaginal Births Using

Birth Certificate and Hospital Discharge Data, Massachusetts, 1998-2003



Declercq et al
OBGYN 2007;
109:669

Rehospitalization of Mothers by Method of Delivery, Mass. 1998-2003

	Planned Vaginal Birth Rehosp. Rate/1,000 (n = 240,754)	Planned Primary Cesarean (n = 3,334)		
		Rehosp. Rate/ 1,000 NIR PCS Births	Unadjusted Odds Ratio (95% CI)	Adjusted* Odds Ratio (95% CI)
1-30 days Postpartum	7.5	19.2	2.6 (2.01-3.33)	2.3 (1.74-2.90)
31-180 days Postpartum	9.8	13.5	1.4 (1.02-1.86)	1.6 (1.08-1.98)
181-365 days Postpartum	9.2	14.6	1.6 (1.19-2.13)	1.8 (1.32-2.38)

* Adjusted for age, race/ethnicity, parity;

Source: Declercq et al. *OBGYN* forthcoming

Postpartum rehospitalization (1-30 days) rates by diagnosis for mother by MoD, Massachusetts, 1998-2003

Planned Vaginal (n= 240,754)		Planned Cesarean (n=3,334)	
Cause	Rate/1,000	Cause	Rate/1,000
Major puerperal infection	1.83	Complication of obstetrical wounds	6.60
Nonpurulent mastitis	0.73	Major puerperal infection	3.30
Delayed & secondary postpartum hemorrhage	0.62	Care and observation	2.40
Infections of the genitourinary tract	0.54	Inflammatory diseases of uterus	1.50
Complication of obstetrical wounds	0.46*	Infections of the genitourinary tract	1.50
Other complications	0.44	Delayed & secondary postpartum hemorrhage	1.20

* For unplanned cesareans alone rate was 5.26/1,000

Source: Declercq et al. *OBGYN* forthcoming

National Institutes of Health
State-of-the-Science Conference Statement
Cesarean Delivery on Maternal Request
March 27–29, 2006

- ***Maternal length of hospital stay.***

Cesarean delivery, planned or otherwise, requires a longer hospital stay than vaginal delivery does. However, these analyses are affected by comparing planned and unplanned cesarean deliveries to all vaginal deliveries. Numerous factors also may influence length of hospital stay, including obstetric complications, insurance coverage, regional practice patterns, health care provider and patient preference, and neonatal hospital stay.

Length of Stay & Average Costs for Hospitalizations of Mothers by MOD, MA, 1998-2003

	Planned Vaginal (n=240,754) (95% CI)	Planned Cesarean (n=3,334) (95% CI)
Initial Hospital Stay		
Length of Stay	2.4 (2.43-2.44)	4.3 (4.27-4.35)
Average Costs [^]	\$2,513 (\$2,507-\$2,519)	\$4,373 (\$4,304-\$4,441)
Subsequent Rehospitalization in 12 mos. Postpartum		
Length of Stay	3.9 (3.75-4.04)	4.3 (3.56-5.12)
Costs [^]	\$5,436 (\$5,221-\$5,651)	\$6,100 (\$4,745-\$7,455)

[^]Charge data adjusted by cost to charge ratios & inflation ; 2003 dollars

Infant Outcomes

BIRTH 35:1 March 2008

Neonatal Mortality for Primary Cesarean and Vaginal Births to Low-Risk Women: Application of an “Intention-to-Treat” Model

*Marian F. MacDorman, PhD, Eugene Declercq, PhD, Fay Menacker,
DrPH, CPNP, and Michael H. Malloy, MD, MS*

“Intention to Treat” Model

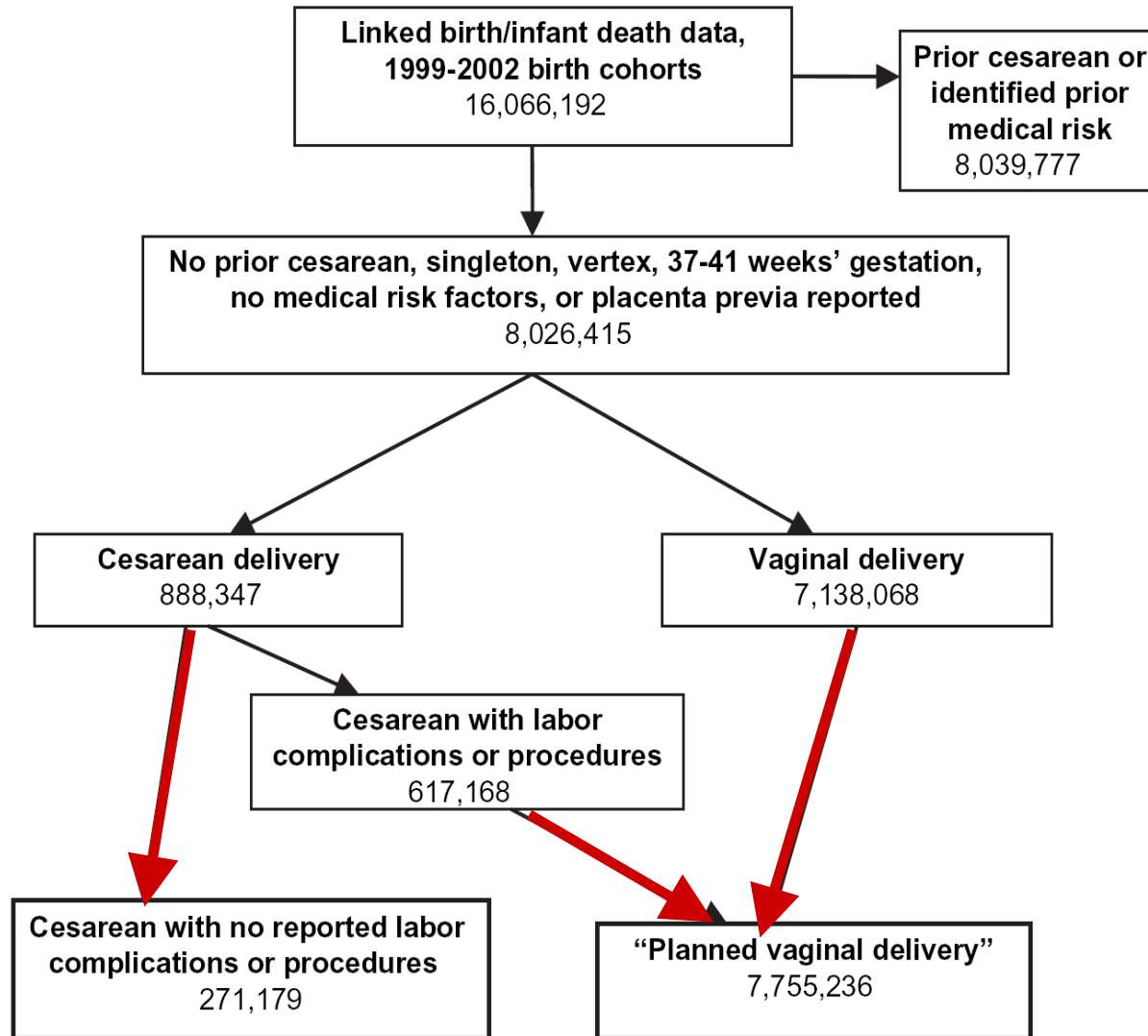


Fig. 1. Distinguishing between planned vaginal births and cesareans with no reported labor complications or procedures.

Neonatal Deaths & Mortality Rates for Low Risk Women by Method of Delivery, 1999-2002

Method of Delivery	Neonatal deaths	Neonatal mort. Rate (per 1,000)
Total	6,014	0.75
Cesarean no labor complications	469	1.73
Deliveries with labor (planned vaginal)	5,546	0.72
Vaginal with & no labor complications	4,500	0.63
Cesarean with labor complications	1,046	1.69
Ratio cesarean no compl./planned vag.		2.42

Includes singleton, term (37-41 weeks gestation), vertex presentation births with no medical risk factors and no prior cesarean. Rates per 1,000 live births

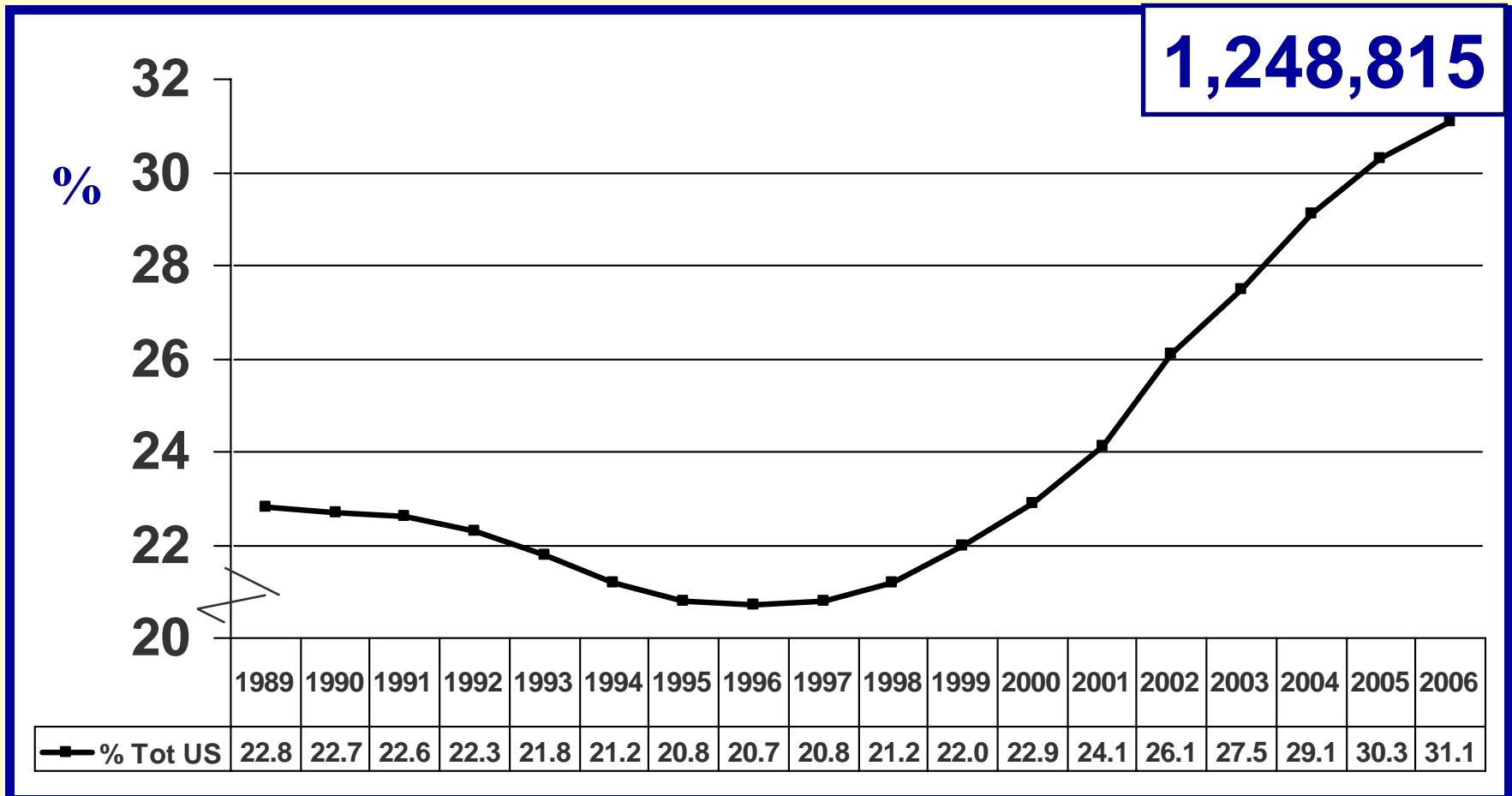
Adjusted Odds Ratios for Neonatal Mortality for Low-Risk Women by Method of Delivery, US 1999-2002 Birth Cohorts

Logistic regression model	Method of delivery	Adjusted odds ratio ¹ and 95% CI
Model 1: Dep. variable= neonatal mortality	'Planned vaginal ² '	1.00
	Cesarean no complications	2.34 (2.13-2.58)
Model 2: Dep. variable= neonatal mortality excl. congenital anomalies	'Planned vaginal ² '	1.00
	Cesarean no complications	1.93 (1.67-2.24)
Model 3: Dep. variable= neonatal mortality excl. cong. anom. and Apgar<4	'Planned vaginal ² '	1.00
	Cesarean no complications	1.58 (1.35-2.11)

1 Adjusted for maternal age, race/ethnicity, parity, education, smoking, period of gestation and birthweight.

2. Includes all vaginal deliveries and cesareans with labor complications.

Are U.S. Women the Reason for the Increasing Cesarean Rate?

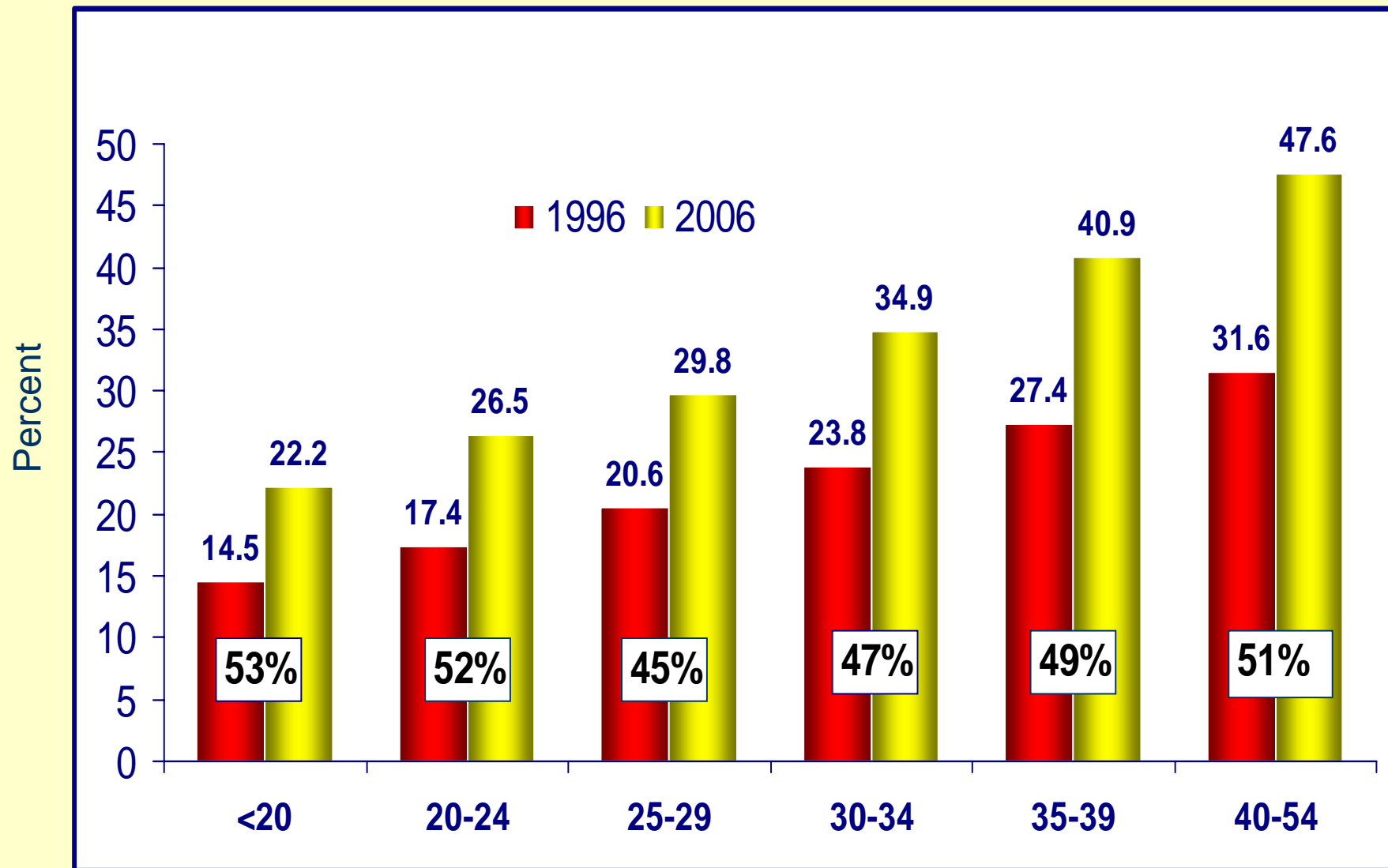


Source: National Center for Health Statistics Annual Birth Reports

Media attention on caesarean delivery with emphasis on “maternal request”

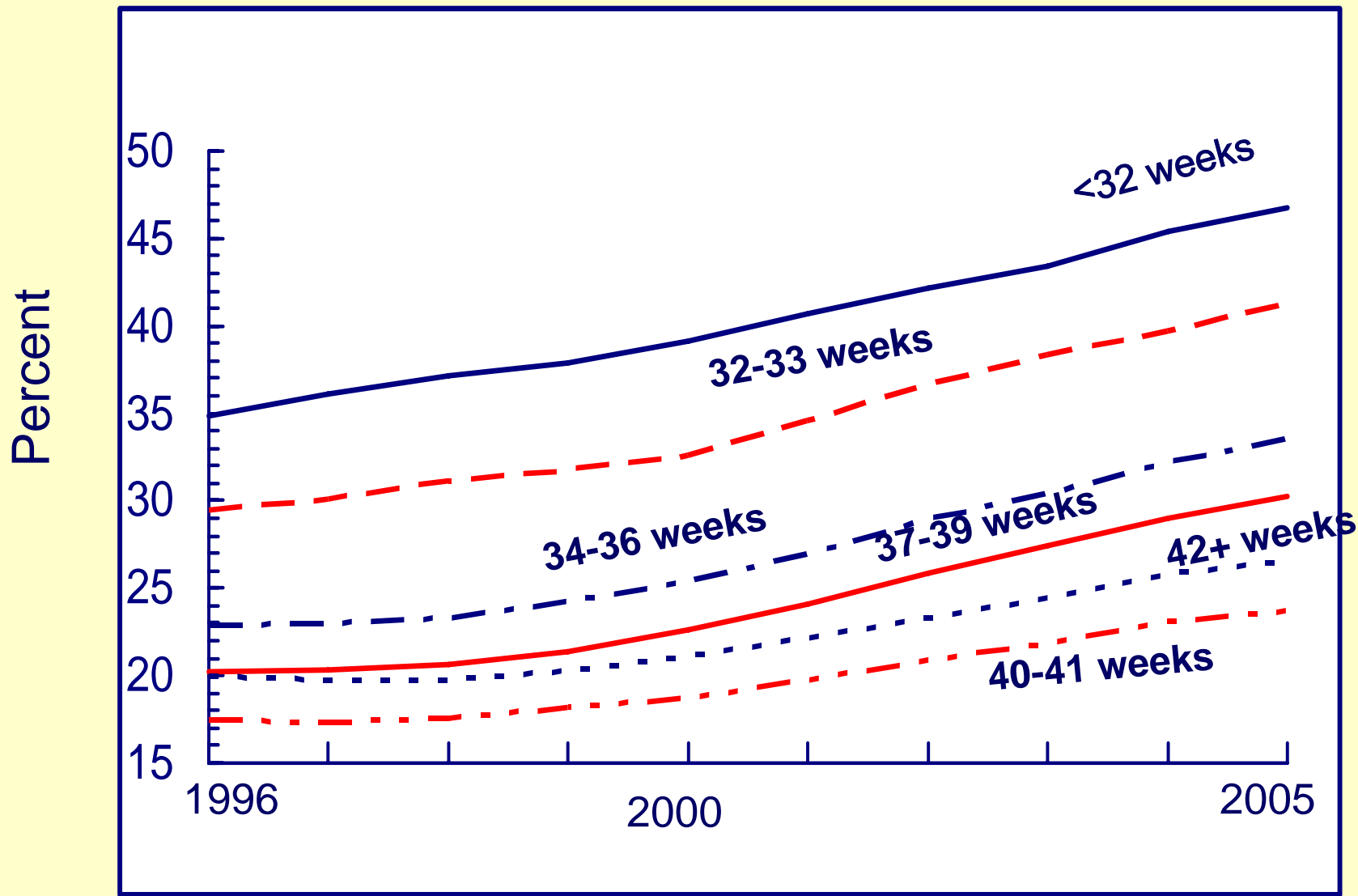
- “Choosy Mothers Choose Caesareans”
Time Magazine 4/17/08
- “‘Too posh to push’ theory backed by caesarean study” *Times of London. 7/3/05*
- “More women turn to cesarean section”
Philadelphia Inquirer 3/20/05
- “Too Posh to Push? Cesarean sections have spiked dramatically” *US News and World Report 8/5/02*

Total Cesarean Rates (per 100 births) by Age of Mother: United States, 1996 and 2006



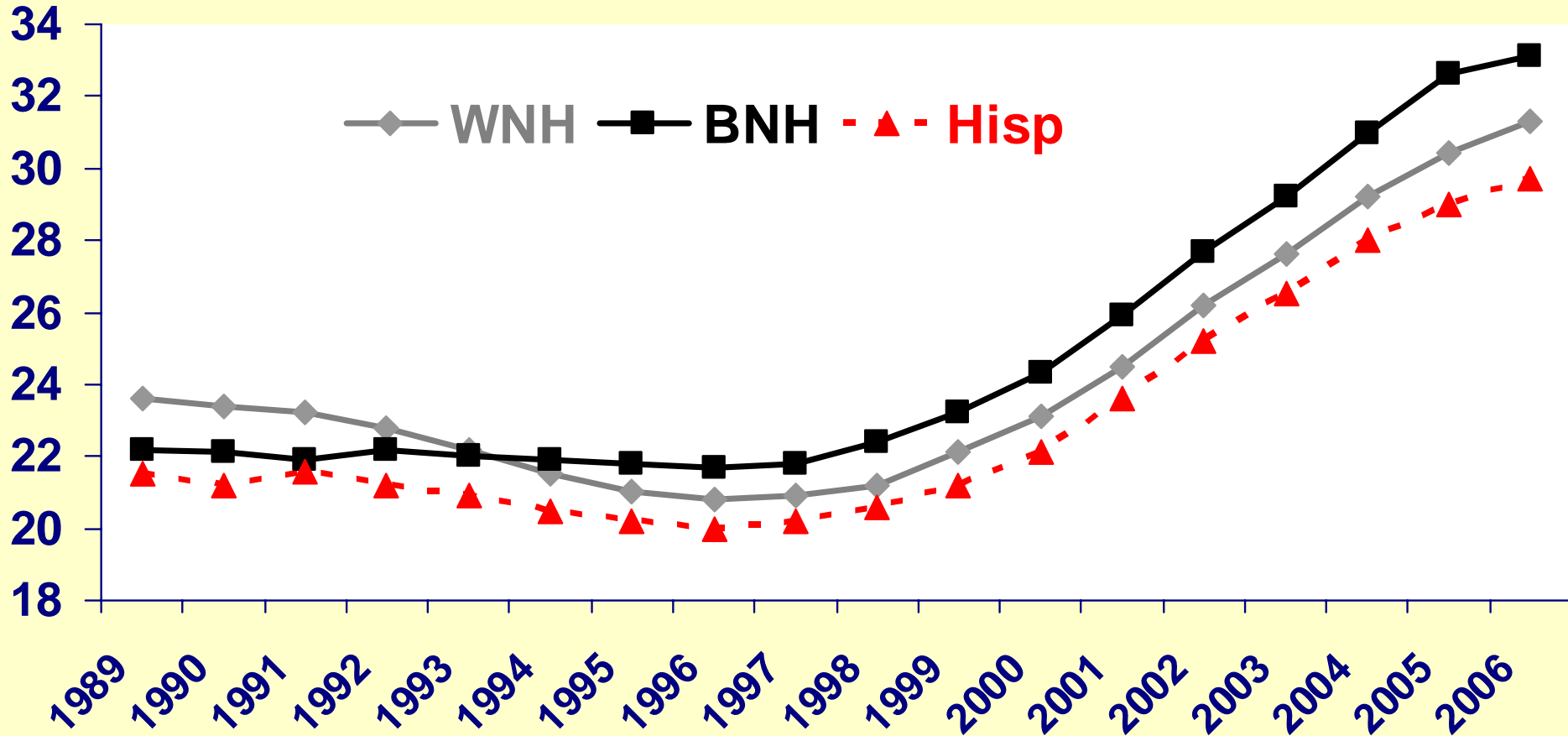
Source: National vital statistics system, NCHS, CDC. Data for 2006 are preliminary.

Total Cesarean Rates by Gestational Age, Singleton, U.S. 1996-2005

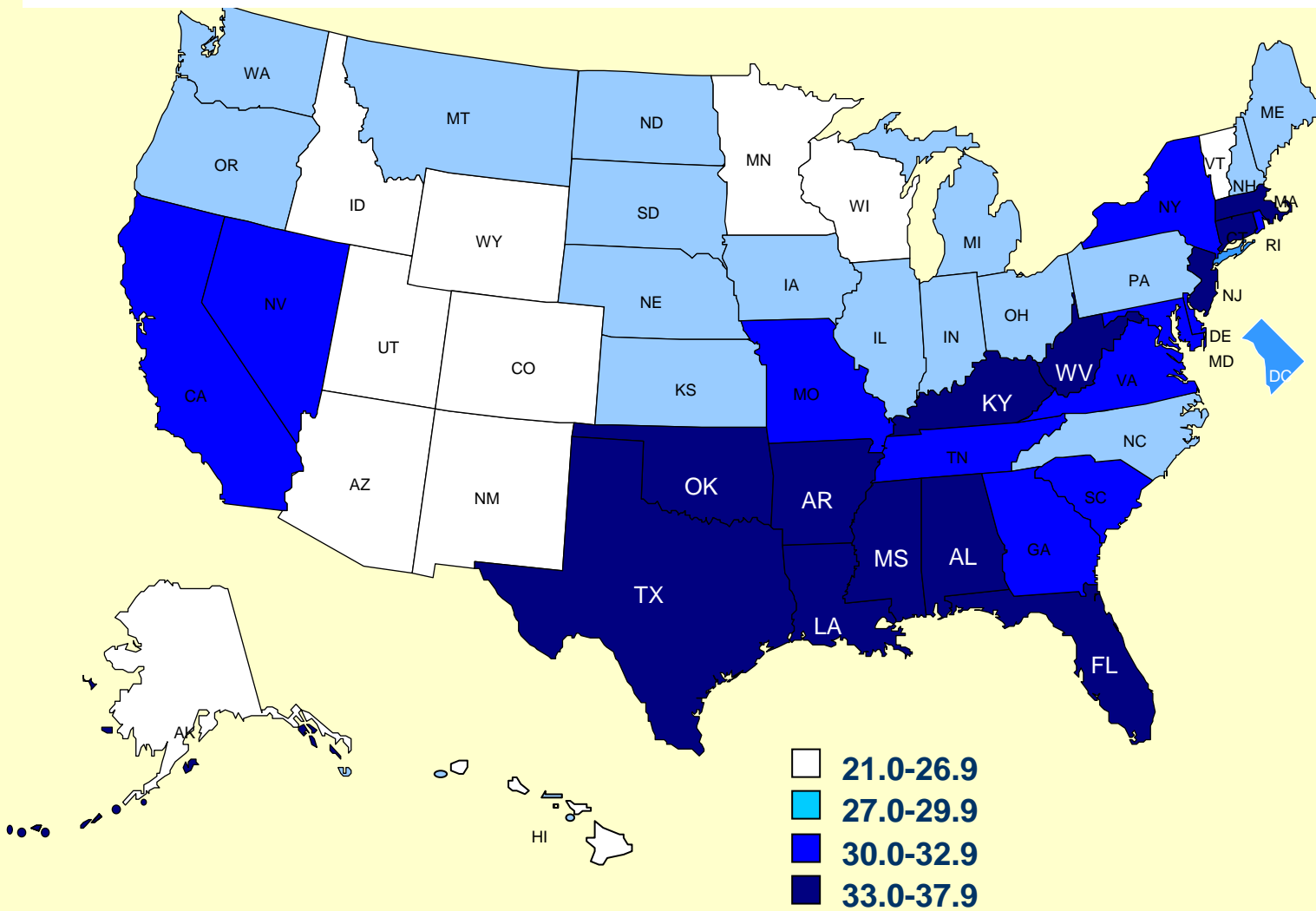


Source: National vital statistics system, NCHS, CDC

Total cesarean rates by race/ethnicity, U.S. 1989-2006



Total Cesarean Delivery Rates by State, United States: 2006 (preliminary)



Have maternal
request cesareans
played a major role in
these increases?

A photograph of four diverse women smiling and holding a baby. The image is faded and serves as a background for the text.

***Asking Mothers about
Maternal Request Cesareans***

Listening to

<http://www.childbirthconnection.org>

Mothers

Eugene R. Declercq

Carol Sakala

Maureen P. Corry

Sandra Applebaum

Two Components to Maternal Request Primary Cesarean

1. Mother made request for planned cesarean before labor
2. Cesarean for no medical reason

Patient Choice Primary Cesareans

- Combining reason for cesarean and timing of decision found only 1 respondent of 252 (0.4%) had a planned primary cesarean for no medical reason.

"I think that [cesarean] is... the best way ... to give birth. It is a planned way, no hassle, no pain, the baby doesn't struggle to come out, the baby is not pressed to come out ...I think that ... everybody should have the baby by cesarean section."

Studies from England and Canada confirm very low rates of maternal request cesareans

International Findings

England¹

Canada²

Sweden³

Australia⁴

When you apply the 2 criteria – prior request and no medical indication, rates of primary Caesarean Delivery on Maternal Request also appear in the 0.5% -2% range.

1.Redshaw M. et al. *Recorded Delivery: a national survey of women's experience of maternity care 2006*. Oxford: National Perinatal Epidemiology Unit, 2007.

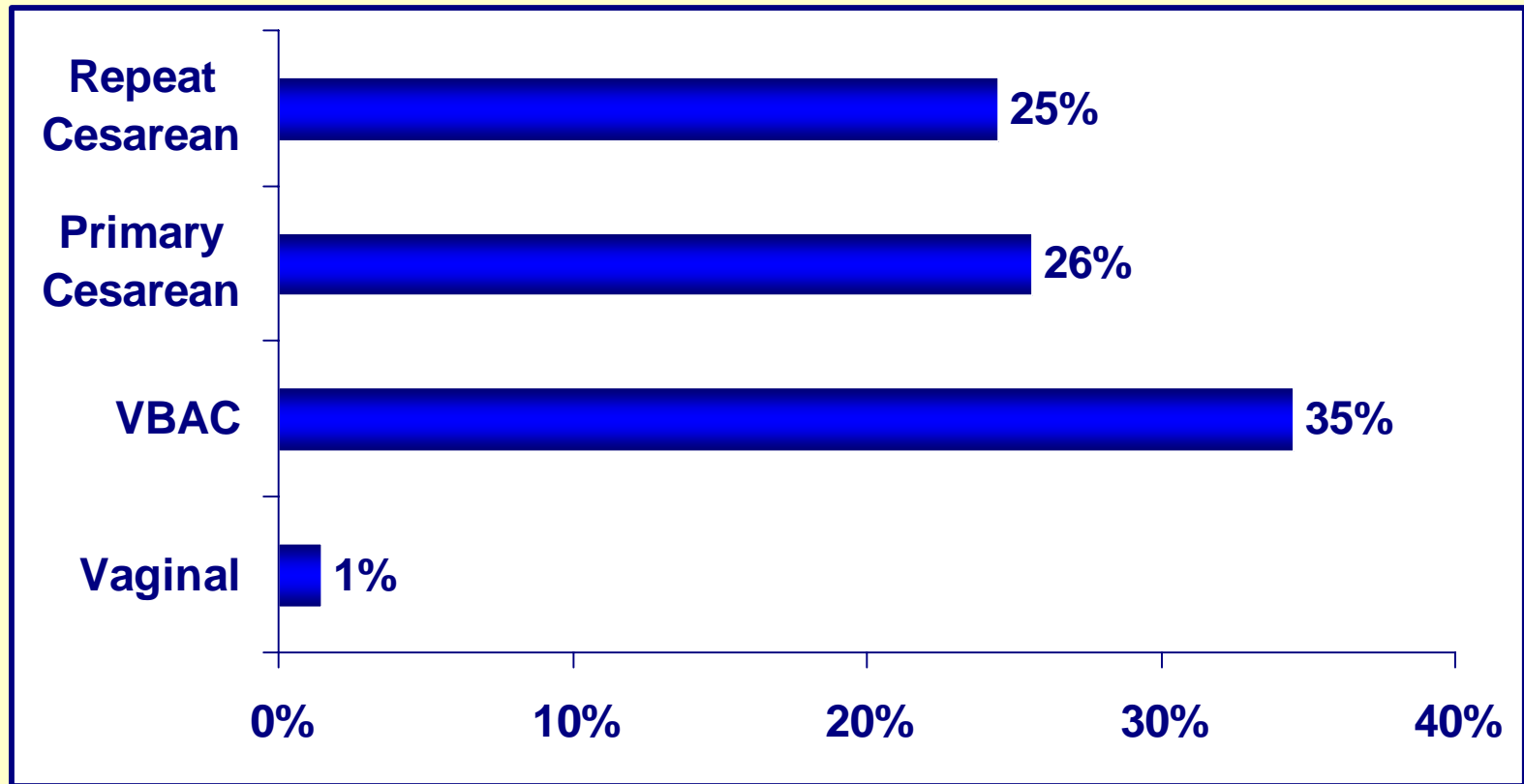
2.Chalmers B. et al. The Canadian Maternity Experiences Survey: An Overview of Findings. *J Obstet Gynaecol Can* 2008;30(3):217–228.

3. HildingssonI. et al. Few women wish to be delivered by CS. *BJOG* 2002; 109:618-623. HildingssonI. How much influence do women in Sweden have on CS? *Midwifery* 2008; 24:46-54; personal communication.

4. Gamble J et al. Women's preference for a cesarean section. *Birth* 2001;28:101-110.

Pressure to Accept Interventions by Method of Delivery

Did you feel pressure from any health professional to have a cesarean? % yes



Source: Declercq et al. 2006. *Listening to Mothers II*.

How does pressure happen?

- *About 4 or 5 hours after my water broke I wasn't progressing much. One of the doctors on duty (not my midwife) came in and wanted to do a cesarean. I did not want to have a c-section unless it was medically necessary or the baby was in trouble. Feeling pressured to do something I didn't want to do was the worst thing. In the end, I asked this doctor if we could give it a little more time, she said okay but she didn't think it would do any good. When she came back to check again I was dilated to 10cm and was able to give birth vaginally. So everything worked out the way I wanted to in the end, but only because I spoke my mind and didn't give in to the pressure.*

Mothers' support for maternal choice in mode of birth (w)

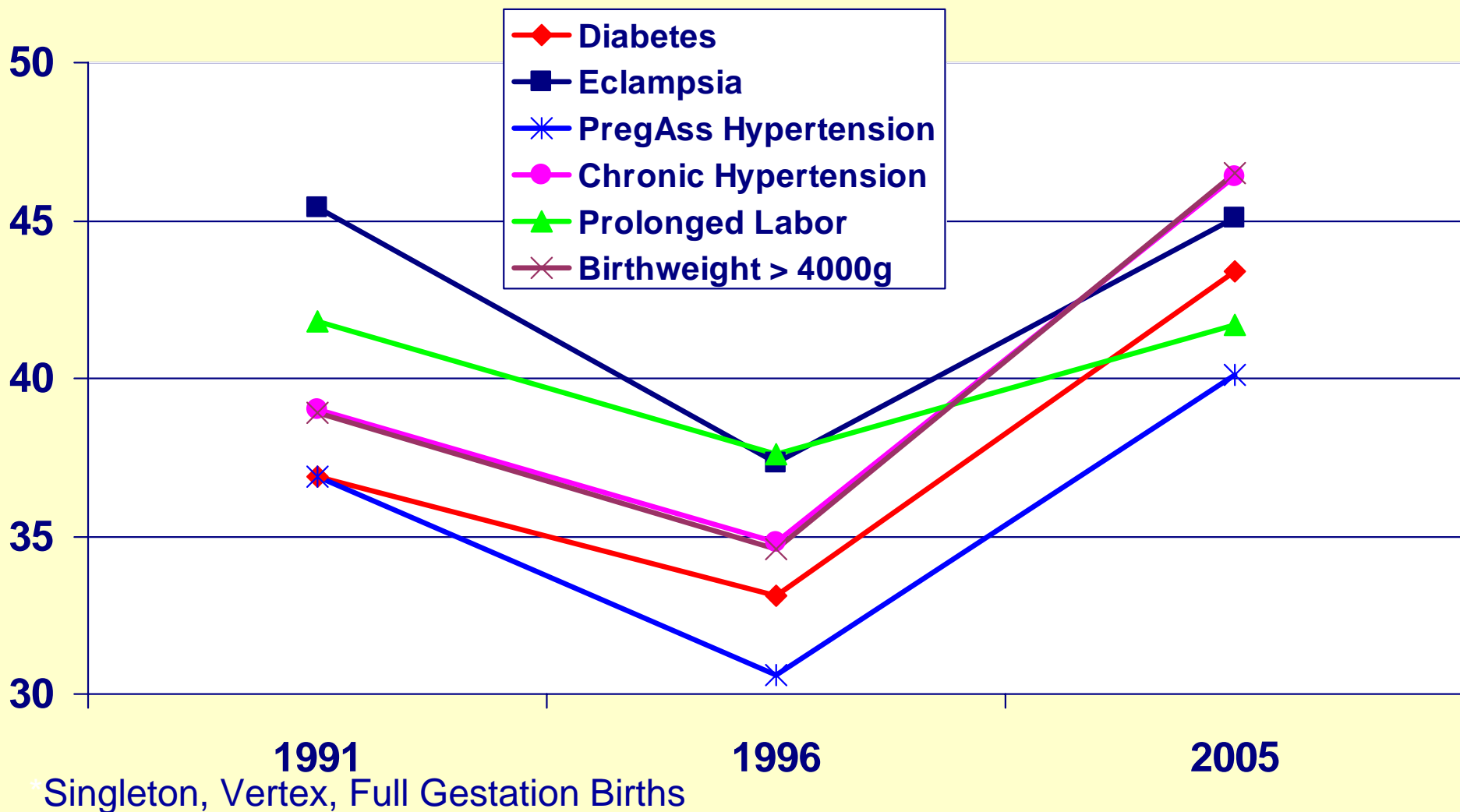
	Disagree & Strongly Disagree	No Opinion	Agree	Strongly Agree
<i>If a woman who has never had a cesarean wants to have a cesarean, she should be able to do so.</i>	31%	23%	20%	26%
			46%	
<i>If a woman who has never had a cesarean wants to have a vaginal birth, she should be able to do so.</i>	1%	7%	13%	80%
			93%	
<i>If a woman who has had a prior cesarean wants to have a vaginal birth, she should be able to do so.</i>	5%	10%	29%	56%
			85%	

Have maternal request cesareans played a major role in these increases?

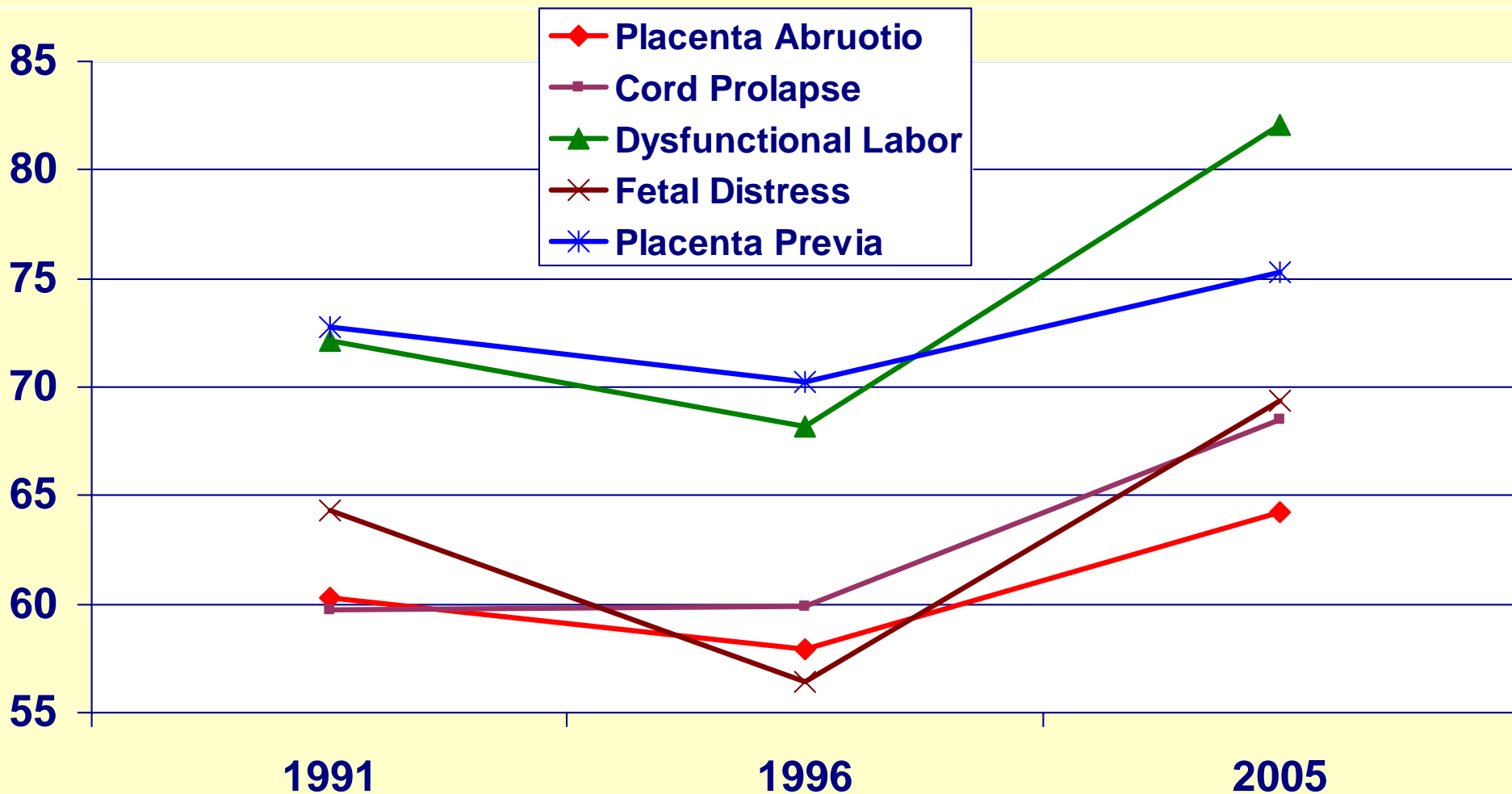
NO!

So what is the reason for the increasing cesarean rate?

Cesarean Rates, Low Risk*, First-Time Mothers for Medical Risk Factors & Labor Complications



Cesarean Rates, Low Risk*, First-Time Mothers for Labor Complications



*Singleton, Vertex, Full Gestation Births

British Journal of Obstetrics and Gynaecology

June 1998, Vol. 105, pp. 621-626

The rise in caesarean section rate: the same indications but a lower threshold

C. R. Leitch Senior Registrar, J. J. Walker Professor (Obstetrics and Gynaecology)

University Department of Obstetrics and Gynaecology, Glasgow Royal Maternity Hospital

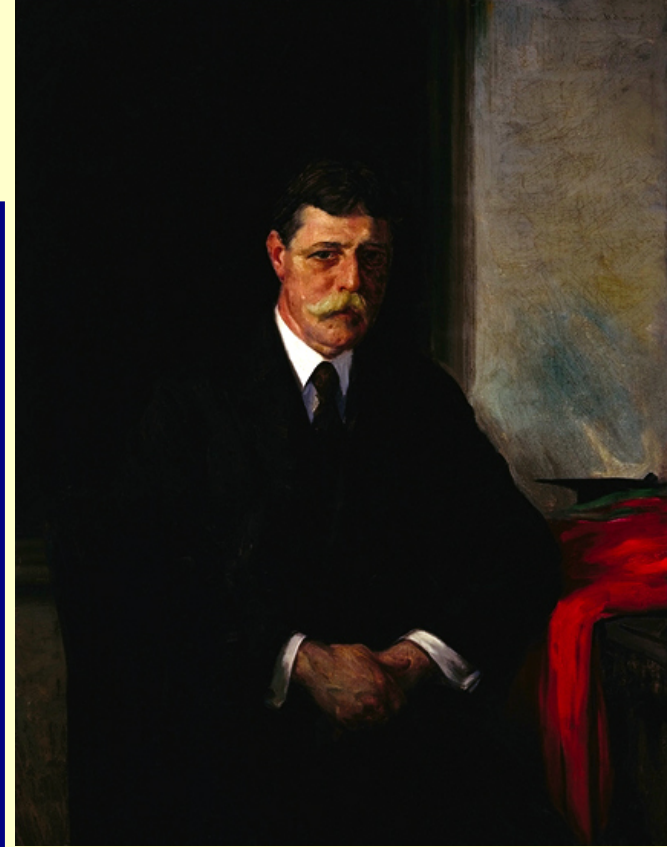
Women have not changed nearly as much as practice patterns have

John Whitridge Williams

pioneer of academic obstetrics

Unfortunately, history shows that advances in the practice of medicine and surgery are rarely attained in a thoroughly rational manner, but that a period of undue enthusiasm, or even of almost reckless abuse, usually precedes the establishment of the actual value of a given procedure.

“[Cesarean section] requires only a few minutes of time and a modicum of operative experience; while [vaginal birth] often implies active mental exertion, many hours of patient observation, and frequently very considerable technical dexterity.



Mothers Rating of the Maternity Care System

	US Health Care	US Maternity Care
Excellent	17%	35%
Good	53%	48%
Fair	26%	15%
Poor	4%	1%

Source: Declercq et al. 2006. *Listening to Mothers II*.

How do we explain disconnect
between high levels of
intervention and mother's
generally positive attitudes
about the U.S. maternity care
system?

Perfect description of the philosophy of contemporary maternity care

Creating a crisis atmosphere is essential to the 1 percent doctrine and its ability to override all obstacles -- be they constitutional restrictions on national security measures or concerns about the United States ranking last among industrialized countries on infant mortality. Such an atmosphere encourages more centralized decision-making and stifles debate. The fact that most of these crises never occur and that countless resources are expended to prevent something that was unlikely to happen anyway is lost in the relief of the immediate positive outcome (a healthy baby or no terrorist attack). In the long run, however, we've wasted time and money, created new problems, and ignored systematically documented, if less emotional, evidence.

Changes Underway??

1. Research on Outcomes
2. Leveling/Decline in cesarean rates cross-nationally
3. Changes in media coverage
4. Expert Meetings
5. Increase in Home Births
6. New Midwifery activism
7. New Childbirth Activism

Research on Outcomes

Questioning Elective Cesareans

- VillarJ et al. Maternal and neonatal individual risks and benefits associated with caesarean delivery: multicentre prospective study. *BMJ*. 2007.335;1025-29

“Caesarean delivery independently reduces overall risk in breech presentations and risk of intrapartum fetal death in cephalic presentations but increases the risk of severe maternal and neonatal morbidity and mortality in cephalic presentations.”

Research on Outcomes

Questioning Elective Cesareans

- LiuS et al. Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term. *CMAJ* 2007; 176(4):455-60.

“Although the absolute difference is small, the risks of severe maternal morbidity associated with planned cesarean delivery are higher than those associated with planned vaginal delivery. These risks should be considered by women contemplating an elective cesarean delivery and by their physicians.”

Research on Research

Current Commentary

Clinical Expert Series



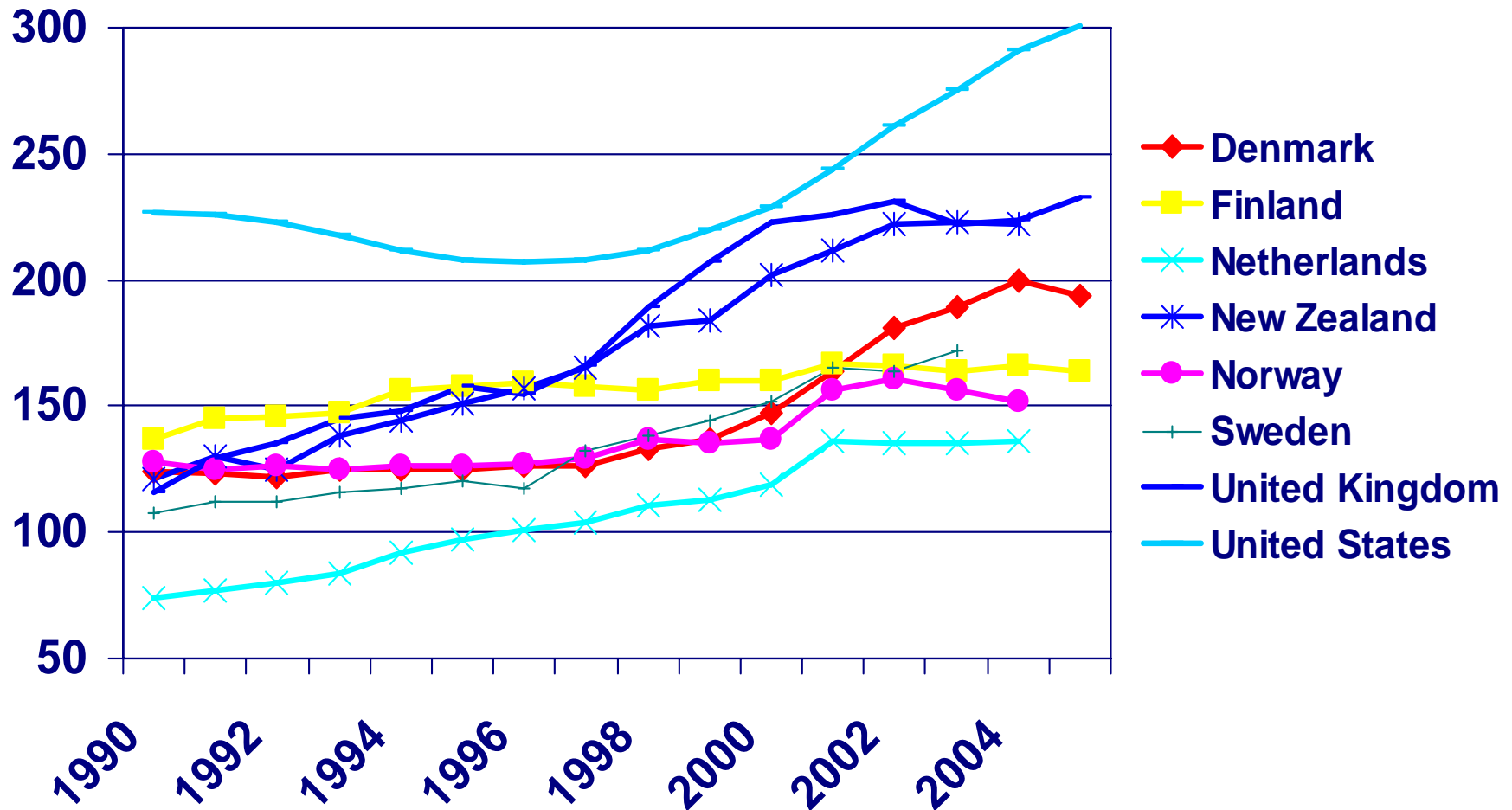
Continuing medical education is available online at www.greenjournal.org

Do Clinical Experts Rely on the Cochrane Library?

David A. Grimes, MD, Melody Y. Hou, MD, Lauren M. Lopez, PhD, and Kavita Nanda, MD, MHS

Fifty-four Clinical Expert Series articles were published from inception of the series in 2002 through June of 2007.We found 187 instances of Cochrane reviews that were potentially relevant to the Clinical Expert Series articles. ... Of the 187 opportunities, 40 citations were found in the articles (21%; 95% CI 16–28%). No temporal trends were evident either in the proportion of Clinical Expert Series articles citing one or more relevant reviews or in the overall proportion of relevant reviews cited. The overall proportion of eligible reviews cited by year ranged from 5% to 32%. (p.421)

Is a rising caesarean rate inevitable?



Changes in Media Coverage

Articles on Rising Cesarean Rate More Commonly Include Statements as Below:

- “[women are] reportedly asking for C-sections even though there is no medical reason for one. **How much so-called maternal request cesareans have contributed to the soaring C-section rate isn't known,** but growing numbers of women are delivering their first babies via surgery, researchers say. *USAToday* 1.7.08
- Before long, the media were reporting that growing numbers of women were demanding that they go under the scalpel for their first births because, well, they preferred to. ***But efforts to quantify this demand have found it doesn't really exist.*** *Phil Inquirer* 6.10.07
- “How often pregnant women order C-sections on demand isn't known But beyond [repeat cesareans], **doctors may be pushing scheduled surgery more often these days.**” *U.S.News & World Report* 1.23.08

Expert Meetings

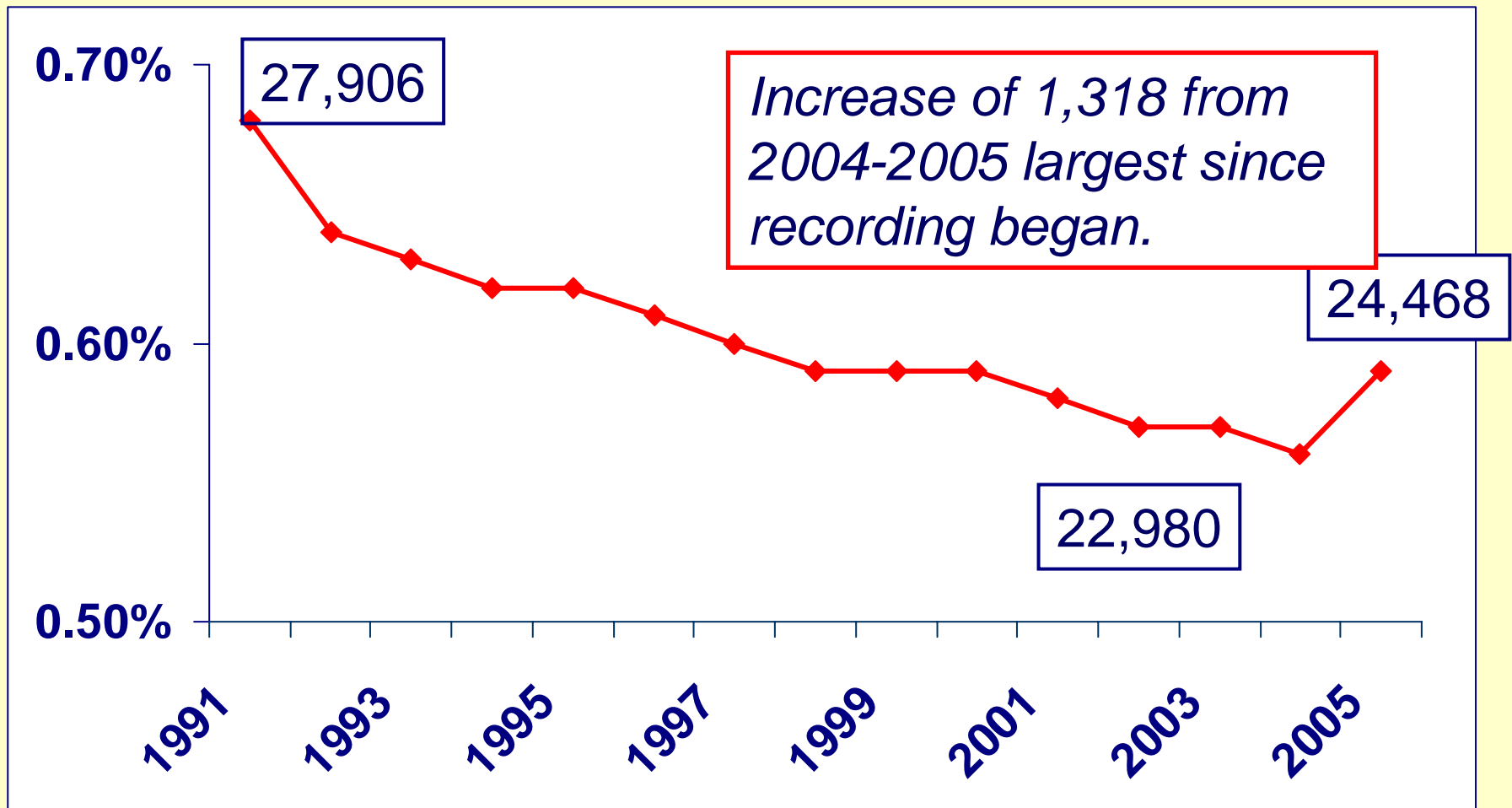
- International Workshop to Define Research Methods to Estimate and Monitor Trends in Cesarean Delivery, Its Determinants and Subsequent Outcomes
- NIH Planning Meeting to Review Literature on VBACs
 - Discussions on meeting to review research
 - Positive news?

Expert Meetings

- **How can things get worse for VBACs?**
- NICHD has funded a number of studies that have examined the risks of VBACs and repeat cesareans

Increase in Home Births

Proportion of Home Births, U.S., 1991-2005



Home Birth an Issue Again

AMER MED ASSOC. HOUSE OF DELEGATES

- Resolution: 205 (A-08)
- Introduced by: American College of OBGYN
- Subject: Home Deliveries
- Referred to: Reference Committee B

Whereas, Twenty-one states currently license midwives to attend home births, all using the certified professional midwife (CPM) credential (CPM or "lay" midwives)

Whereas, There has been much attention in the media by celebrities having home deliveries, (Ricki Lake)

Whereas, An apparently uncomplicated pregnancy or delivery can quickly become very complicated ...necessitating the need for the availability of emergency care

Home Birth an Issue Again

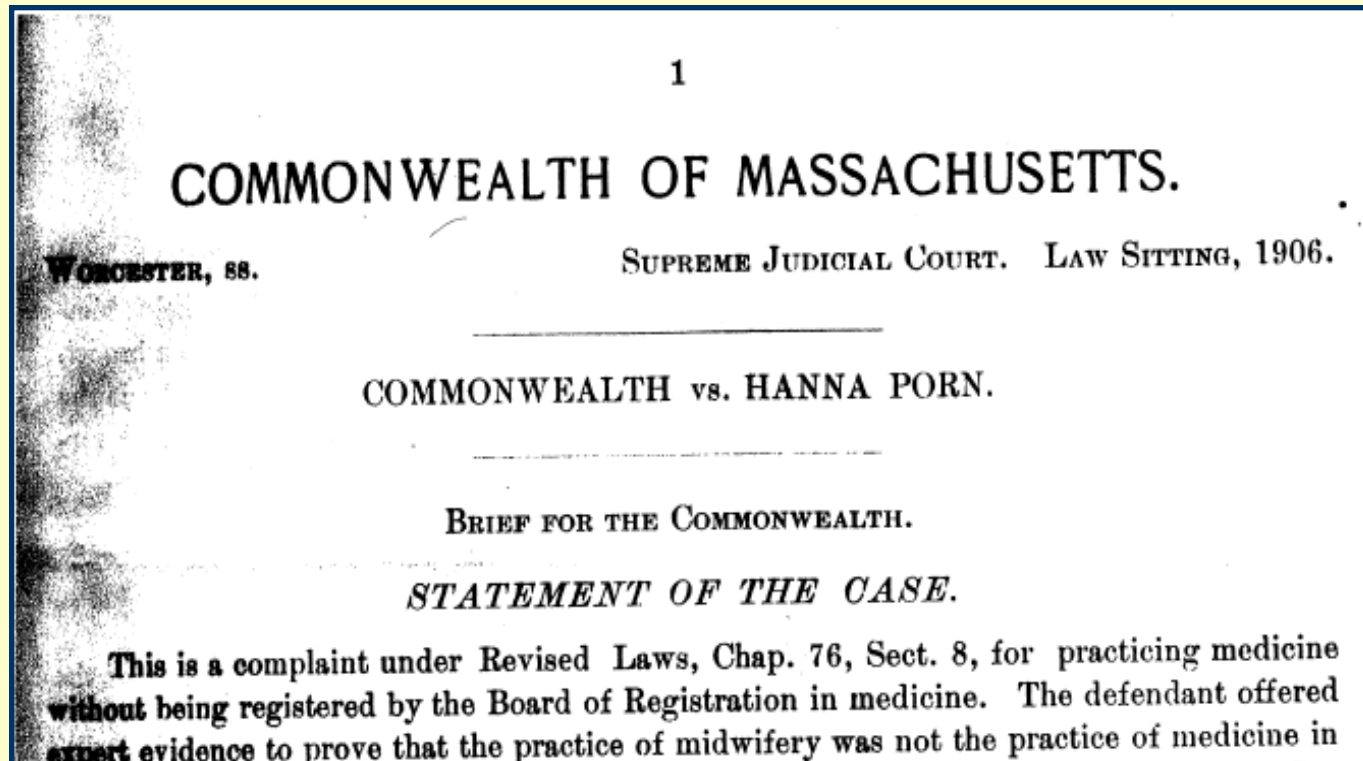
AMA HOUSE OF DELEGATES Res.205

RESOLVED, *That our AMA develop model legislation in support of the concept that the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, or in a freestanding birthing center that meets the standards of the AAAHC, JCAHO, AABC.*

(Directive to Take Action)

Received: 04/28/08

Old Midwifery Activism

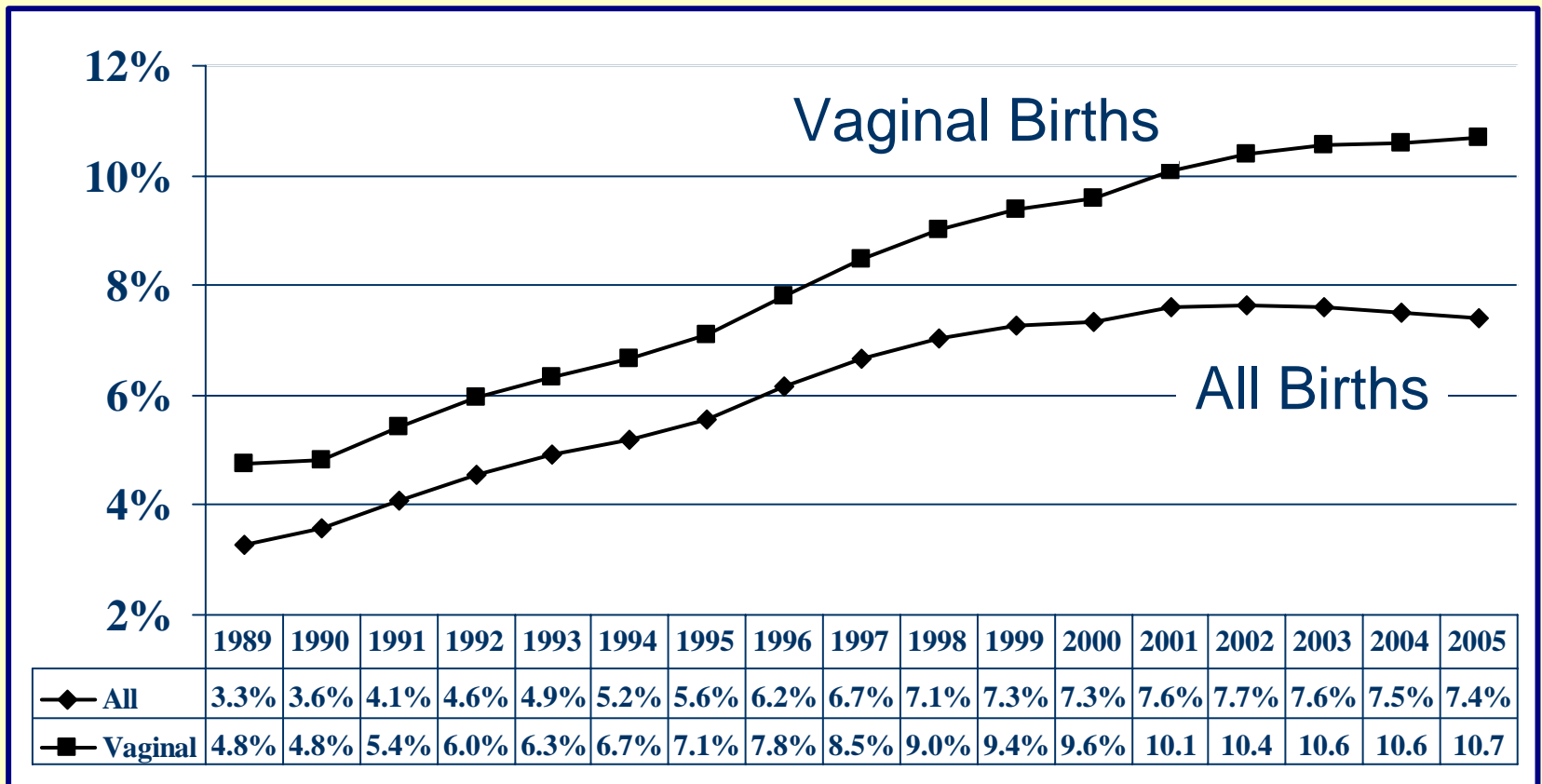


the court suggested that it would be possible for "the Legislature to separate by a line of statutory demarcation the work of the midwife from that of the practitioner of medicine." However, their prevailing interest was with "the maintenance of a high standard of professional qualifications for physicians."

Source: Declercq E. The trials of Hanna Porn. *AJPH*. 1994; 84:1022-1028.

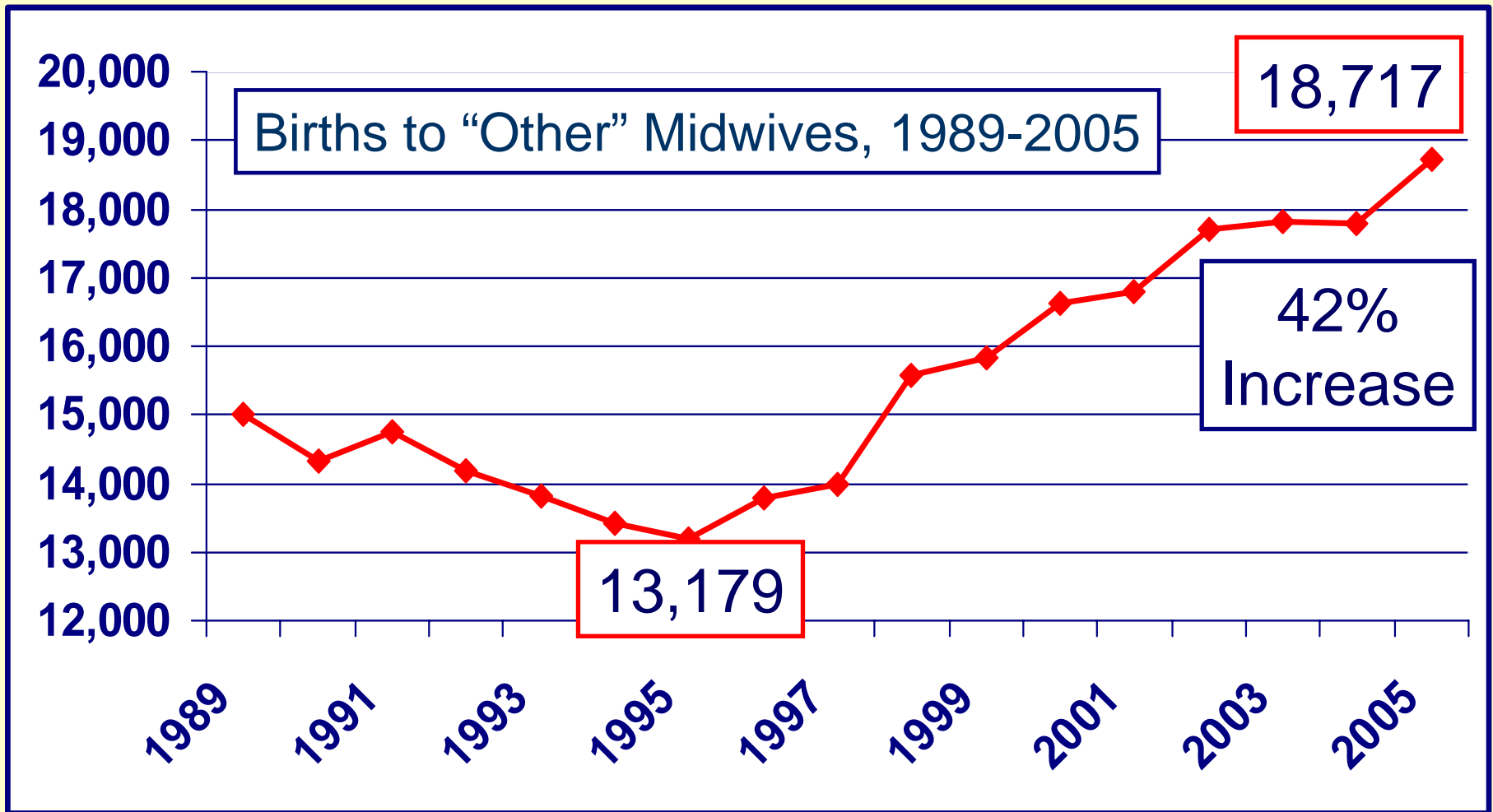
New Midwifery Activism

Percentage of Live Births Attended by CNM's 1989 - 2005



Source: National Center for Health Statistics, *Final Data Births*, annual reports, 1989-2005

New Midwifery Activism



New Midwifery Activism

SENATE, No. 2636

The Commonwealth of Massachusetts



IN THE YEAR OF TWO THOUSAND AND SEVEN

Is collaboration the future?

AN ACT ESTABLISHING A BOARD OF REGISTRATION IN MIDWIFERY

New Midwifery Activism

From Mass. Chapter of ACOG

*This legislation would empower private national organizations — the American College of Nurse Midwives (ACNM) and the North American Registry of Midwives (NARM) — to set standards for the licensing of nurse-midwives and non-nurse midwives. **It is important to note that the ACNM accepts non-nurse-midwives into its ranks** and has engaged in a national legislative program to have its members licensed to provide obstetric, gynecological, pediatric, and primary health care services to women and their families. **In general non-nurse midwives do not have the broad science, clinical science and practice experience that is mandatory for clinical practice.***

New Childbirth Activism